



**Emergency Systems for Advance Registration of Volunteer  
Health Professionals (ESAR-VHP) Program**

**Interim Technical and Policy Guidelines,  
Standards, and Definitions**



Department of Health and Human Services  
Health Resources and Services Administration  
Healthcare Systems Bureau  
Division of Healthcare Preparedness  
ESAR-VHP Program

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## About the Guidelines

Developing a health care workforce emergency surge capacity is an essential component of health care preparedness. Expanding the physical capacity of our Nation's hospitals and other health care facilities alone will not result in effective surge capacity without the health care personnel needed to run the equipment and deliver patient care. The Interim Technical and Policy Guidelines, Standards, and Definitions, referred to as the "Guidelines," are designed to assist awardees under the National Bioterrorism Hospital Preparedness Program (NBHPP) in meeting Critical Benchmark #2-4: Surge Capacity: Advance Registration System of the FY 2005 Continuation Guidance.

*Critical Benchmark #2-4: Surge Capacity: Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP).*

Develop a system that allows for the advance registration and credentialing of clinicians needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs.

Meeting this benchmark is a critical milestone in determining the preparedness of the nation's health care system. This guide provides a basic set of recommendations and approaches to developing, implementing, and maintaining state-based Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

These Guidelines are one of three reports supporting the Health Resources and Services Administration's (HRSA) ESAR-VHP program. The other reports include the Hospital Implementation Issues report, which deals with issues specifically affecting hospitals, and the Legal and Regulatory Issues report, which deals with the relevant legal and regulatory issues that may affect ESAR-VHP development, implementation, and activation.

The Guidelines are a living document, and will be routinely updated and revised. Your comments and suggestions are welcome. Please direct your comments or additional information for the Guidelines to [comments@esarvhp.com](mailto:comments@esarvhp.com).



## Acknowledgments

The ESAR-VHP Interim Technical and Policy Guidelines, Standards, and Definitions are the product of extensive ongoing collaboration across the United States. The result is intended to assist States in meeting the needs and priorities of the nation's health care system by protecting our nation's communities through proper planning and the development of improved systems to utilize our nation's medical and health care professionals who, during emergencies, volunteer to provide health services. HRSA is grateful for the expertise, insights, and commitment of all State representatives participating in the national working groups and the program advisory group, and for organizations who have contributed to this effort including the American Association of Colleges of Nursing, American Hospital Association, American Medical Association, American Nurses Association, American Red Cross, Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Centers for Disease Control and Prevention, Collaborative Fusion Inc., Joint Commission on Accreditation of Healthcare Organizations, Joint Commission Resources, ManTech International Corporation, and the Medical Reserve Corps.



## Summary of Changes

Two significant changes have been made to the latest version of the Guidelines. These changes are as follows:

1. Conventions and terminology associated with NIMS Resource Typing have been removed from the Guidelines. The resource identification and credentialing standards utilized in the Guidelines and under the ESAR-VHP program will be referred to as Emergency Credentialing Standards.
2. An additional question has been added as an information requirement in Section 12.4 “Determining Health Volunteer Authorizations and Acknowledgements Information Needs.” Health volunteers will be asked, but not required to answer, the following question:

***In the event of a declared national emergency, would you consider volunteering to work under the auspices of the Federal Government? If you check yes, in the event of a national emergency, the information you provide will made available to the Federal Government upon its request. (Yes / No)***

Should you have questions or comments regarding these changes or related to other areas of the Guidelines, please contact [comments@esarvhp.com](mailto:comments@esarvhp.com).



## Table of Contents

<b>About the Guidelines .....</b>	<b>3</b>
<b>Acknowledgments .....</b>	<b>5</b>
<b>Summary of Changes.....</b>	<b>7</b>
<b>Table of Contents .....</b>	<b>9</b>
<b>1.0 Introduction to ESAR-VHP .....</b>	<b>13</b>
1.1 Overview and Purpose .....	13
1.2 Importance of the ESAR-VHP Program.....	14
1.3 National System Through State Coordination .....	14
1.4 Approach to Developing the Guidelines.....	15
1.5 Ten Key Topics.....	16
1.6 Meeting ESAR-VHP Objectives.....	17
1.7 Desired Outcome .....	17
1.8 Organization of the Guidelines .....	17
<b>2.0 Initial System Planning Activities .....</b>	<b>19</b>
2.1 Overview of Initial System Planning Activities .....	19
2.2 Assigning an ESAR-VHP System Coordinator.....	19
2.3 Forming an ESAR-VHP Program Advisory Group.....	19
2.4 Overview of Ohio's Approach to ESAR-VHP System Planning .....	21
<b>3.0 System Design.....</b>	<b>23</b>
3.1 Overview of System Design .....	23
3.2 Three Primary Functions of the ESAR-VHP System .....	23
3.3 Collecting the Necessary Information to Allow for System Functions .....	26
3.4 System Architecture.....	27
3.5 Future Focus Areas and Needs of the National ESAR-VHP Project.....	28
<b>4.0 Emergency Credentialing Standards .....</b>	<b>29</b>
4.1 Overview of Emergency Credentialing Standards.....	29
4.2 Classifying Health Volunteers According to the Emergency Credentialing Standards	30
4.3 Emergency Credentialing Standards for Physicians .....	33
4.4 Emergency Credentialing Standards for Registered Nurses .....	38
4.5 Emergency Credentialing Standards for Marriage and Family Therapists.....	41
4.6 Emergency Credentialing Standards for Medical and Public Health Social Workers...	42
4.7 Emergency Credentialing Standards for Mental Health and Substance Abuse Social Workers.....	44
4.8 Emergency Credentialing Standards for Psychologists .....	47
4.9 Emergency Credentialing Standards for Mental Health Counselors .....	49
4.10 Notes on Establishing Emergency Credentialing Standards for Behavioral Health Professionals .....	51
4.11 The Value of Developing a System to Provide the Highest Emergency Credentialing Levels.....	51
4.12 Privileging of Health Volunteers .....	53
4.13 State Approaches to Emergency Credentialing and the ESAR-VHP .....	53
4.14 Future Focus Areas and Needs of the National ESAR-VHP Program .....	58

<b>5.0</b>	<b>Training and Situational Orientation .....</b>	<b>59</b>
5.1	Overview of Training and Situational Orientation .....	59
5.2	Integrating Training Information into the ESAR-VHP System.....	59
5.3	Recording Training Information within the ESAR-VHP System.....	60
5.4	Overview of Competency-Based Training .....	61
5.5	Overview of State Approaches to Training and Situational Orientation .....	64
5.6	Future Focus Areas and Needs of the National ESAR-VHP Program .....	64
<b>6.0</b>	<b>Health Volunteer Recruitment and Advocacy .....</b>	<b>65</b>
6.1	Overview of Health Volunteer Recruitment and Advocacy .....	65
6.2	Building ESAR-VHP Awareness and Recruiting New Health Volunteers .....	65
6.3	Techniques to Encourage Registration and Retention of Existing Health Volunteers ..	66
6.4	Protecting the Interests of Health Volunteers .....	67
6.5	Existing State Approaches to Health Volunteer Recruitment and Advocacy.....	69
6.6	Future Focus Areas and Needs of the National ESAR-VHP Program .....	72
<b>7.0</b>	<b>Funding and Cost.....</b>	<b>73</b>
7.1	Overview of Funding and Cost .....	73
7.2	Supplemental Funding and System Sustainability .....	73
7.3	Determining Key Areas for System Cost.....	73
7.4	Future Focus Areas and Needs of the National ESAR-VHP Program .....	76
<b>8.0</b>	<b>Security and Privacy .....</b>	<b>77</b>
8.1	Overview of Security and Privacy .....	77
8.2	Understanding the Security and Privacy Issues Inherent in an ESAR-VHP System ....	77
8.3	Understanding State and Local Privacy Laws .....	78
8.4	Taking Necessary Precautions to Protect Health Volunteer Information .....	78
8.5	Establishing Minimum Security Standards for ESAR-VHP Systems .....	80
8.6	Facilitating Portability and Communication of Health Volunteer Information .....	82
8.7	Future Focus Areas and Needs of the National ESAR-VHP Program .....	82
<b>9.0</b>	<b>Authorities and Emergency Operations .....</b>	<b>83</b>
9.1	Overview of Authorities and Emergency Operations .....	83
9.2	Understanding Unique Legal and Regulatory Structures Surrounding ESAR-VHP Systems .....	84
9.3	Assessing the Existing Legal Issues of the System .....	85
9.4	Delegation of Power to Administer Primary ESAR-VHP Functions .....	88
9.5	Determining the Appropriate Protocols for ESAR-VHP System Use.....	89
9.6	Future Focus Areas and Needs of the National ESAR-VHP Program .....	89
<b>10.0</b>	<b>System Operations and Maintenance.....</b>	<b>91</b>
10.1	Overview of System Operations and Maintenance.....	91
10.2	Assigning a Technical System Administrator and the Responsibilities of a System Administrator .....	91
10.3	Integration of Identification Card with ESAR-VHP Systems .....	93
10.4	Future Focus Areas and Needs of the National ESAR-VHP Program .....	95
<b>11.0</b>	<b>Regionalizing and Nationalizing the ESAR-VHP Program.....</b>	<b>97</b>
11.1	Overview of Regionalizing and Nationalizing the ESAR-VHP System .....	97

<b>12.0</b>	<b>Data Definitions.....</b>	<b>99</b>
12.1	Overview of Data Definitions.....	99
12.2	Determining Health Volunteer Identification Information Needs .....	99
12.3	Determining Health Volunteer Authorizations and Acknowledgements Information Needs.....	101
12.4	Determining Credential and Emergency Credentialing Level Information Needs.....	101
12.5	Occupation: Physician. ....	102
12.6	Occupation: Registered Nurse .....	104
12.7	Occupation: Marriage and Family Therapist .....	106
12.8	Occupation: Medical and Public Health Social Worker .....	107
12.9	Occupation: Mental Health and Substance Abuse Social Worker.....	109
12.10	Occupation: Psychologist.....	110
12.11	Occupation: Mental Health Counselor.....	112
12.12	Determining Supplemental Information Needs .....	114
<b>Appendix 1: State and Institutional Approaches to Training .....</b>		<b>117</b>
A1.1	Overview.....	117
A1.2	Wisconsin’s Approach to Health Volunteer Training Issues.....	117
A1.2	Texas’s Approach to Health Volunteer Training Issues .....	118
A1.3	Connecticut’s Approach to Health Volunteer Training Issues .....	119
A1.4	Georgia’s Approach to Health Volunteer Training Issues.....	120
A1.5	Training Program Development by The International Nursing Coalition for Mass Casualty Education (INCMCE) .....	121
A1.6	Training Program Development By The University of Pittsburgh Medical Center (UPMC) Health System .....	121
<b>Appendix 2: Contributors to State and Institutional Example Approaches to Key Issues</b>		<b>123</b>
<b>Appendix 3: American Board of Medical Specialties and Subspecialties .....</b>		<b>127</b>
<b>Appendix 4: American Osteopathic Association Specialty Boards.....</b>		<b>131</b>
<b>Appendix 5: American Board of Professional Psychology Specialty Boards.....</b>		<b>133</b>
<b>Appendix 6: National Association of Social Workers Specialty Certifications.....</b>		<b>135</b>
<b>Appendix 7: American Board of Nursing Specialties Certifications.....</b>		<b>137</b>
<b>Appendix 8: ESAR-VHP Guidelines Glossary of Terms .....</b>		<b>139</b>
<b>Appendix 9: ESAR-VHP Guidelines Acronyms .....</b>		<b>153</b>
<b>Appendix 10: List of US States and Territories .....</b>		<b>157</b>
<b>Works Cited.....</b>		<b>159</b>



## 1.0 Introduction to ESAR-VHP

### 1.1 Overview and Purpose

The purpose of these Guidelines is to help each State develop a state-based ESAR-VHP System. The ESAR-VHP System is defined as follows:

*ESAR-VHP System* is an electronic database of health care personnel who volunteer to provide aid in an emergency. An ESAR-VHP System must (1) register health volunteers, (2) apply emergency credentialing standards to registered volunteers, and (3) allow for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency.

*Health volunteer* is a medical or healthcare professional that renders aid or performs health services, voluntarily, without pay or remuneration. Health volunteer and volunteer are used interchangeably throughout the document.

The Interim Technical and Policy Guidelines, Standards, and Definitions are designed to help the National Bioterrorism Hospital Preparedness Program community to understand and address the range of issues involved in the development, maintenance, and operation of an ESAR-VHP System. The Guidelines are minimally prescriptive and are designed to provide States with options and flexibility to develop an ESAR-VHP System which best meets the States' needs while enabling a national system of mutual aid. Effective approaches from existing State Systems are also provided to assist States in developing an optimal System.

These Guidelines concentrate on the credentialing and data requirements for:

- Physicians
- Registered Nurses
- Behavioral health professionals (Marriage and Family Therapists, Medical and Public Health Social Workers, Mental Health and Substance Abuse Social Workers, Psychologists, and Mental Health Counselors)

The next version of the Guidelines will include the emergency credentialing standards for the following high priority occupations:

- Advanced Practice Nurses (Nurse Practitioners, Nurse Anesthetists, Certified Nurse Midwives, Clinical Nurses Specialists)
- Physician Assistants
- Dentists
- Emergency Medical Technicians (EMTs) and Paramedics
- Pharmacists
- Licensed Practical Nurses
- Respiratory Therapists
- Respiratory Therapy Technician
- Cardiovascular Technologist and Technicians

- Radiologic Technologists & Technicians
- Surgical Technologists
- Medical and Clinical Laboratory Technologists
- Medical and Clinical Laboratory Technicians (includes Phlebotomists)
- Diagnostic Medical Sonographers
- Veterinarians

After the addition of these priority occupations, subsequent versions will include additional occupations. Ultimately, the Guidelines will include emergency credentialing standards for approximately 65 health and health related occupations.

## **1.2 Importance of the ESAR-VHP Program**

Experience has shown that, in an emergency, many of our nation's health and medical providers are eager and willing to volunteer their professional health services. To meet the extraordinary demands of a large scale emergency, hospitals and other providers of healthcare will depend upon the services that health volunteers can provide. However, in a time of emergency, utilizing the capabilities of the nation's health volunteers presents a major challenge to hospital, public health, and emergency authorities.

Immediately after the attacks on September 11, 2001, tens of thousands of people spontaneously showed up at ground zero in New York City to volunteer their assistance. A large number of these volunteers arrived to provide medical assistance to the victims of the attacks. In most cases, authorities were unable to distinguish those -that were qualified from those that were not qualified, though well intentioned. Additionally, because the response was unsolicited and there was no mechanism of coordination, those that presented themselves reduced the effectiveness of the overall response effort rather than helping.

"We had volunteers just show up -- unsolicited, unneeded, not requested. To accommodate them we had to set up another city. We had to feed them and take care of sanitation and other things. But we just couldn't use them." - Ed Jacoby, Jr., former Director of New York's Emergency Management Office.

In addition to the experiences in New York City in September 2001, similar difficulties have occurred when the nation has had to respond to hurricanes, earthquakes, and other mass casualty events. The goal of the ESAR-VHP program is to eliminate a number of the significant problems encountered when seeking to utilize medical and healthcare volunteers in a complex emergency response situation.

## **1.3 National System Through State Coordination**

The ESAR-VHP program is a State-based approach to establishing a national system. Each State will independently develop, maintain, operate, and command an ESAR-VHP System. However, it is important that all members of the NBHPP community work together to ensure maximum surge capacity by establishing a system that facilitates the exchange of health care workers between jurisdictions. Such a system for mutual assistance will be a national asset. This is best brought about through common definitions, standards, and protocols. In this way, the States'

ESAR-VHP Systems will form a critical network to facilitate the deployment of willing, needed, and qualified health volunteers for any emergency.

These Guidelines are designed to promote the use of the ESAR-VHP Systems in accordance with formal incident command and emergency protocols with proper authorities responsible for the coordination of health volunteers.

#### **1.4 Approach to Developing the Guidelines**

HRSA has developed the ESAR-VHP Guidelines, Standards, and Definitions to serve the strategic and tactical needs of the NBHPP community. In setting the Guidelines, HRSA has formed a set of national working groups to provide expertise and perspective on how to properly address ten key topics confronting the NBHPP community in establishing successful ESAR-VHP Systems. Throughout the life of the ESAR-VHP program, the ten national working groups will serve as the primary mechanism to shape the ongoing development of the Guidelines and to ensure that the Guidelines reflect the NBHPP community's needs. The national working groups consist of representatives from States and national organizations integral to ESAR-VHP program development.

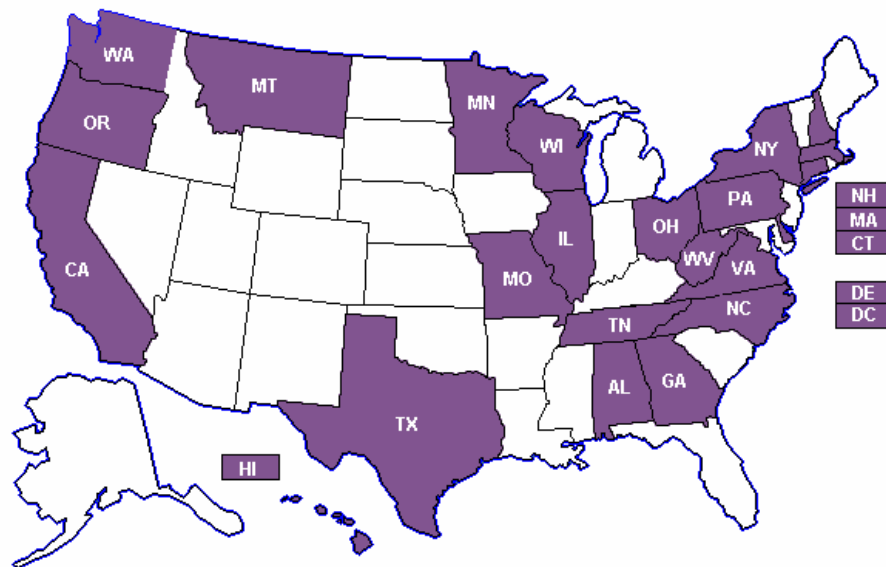
Overall, the Guidelines are designed to provide each State with a high degree of flexibility in developing an effective and useful ESAR-VHP System, while coordinating efforts to create a national network of interoperable systems.

## 1.5 Ten Key Topics

The ten issue working groups and State chairs include:

Issue Working Groups	State Chair
System Design	West Virginia
Emergency Credentialing Standards	Minnesota
Security and Privacy	Wisconsin
Authorities and Emergency Operations	California
Regionalizing and Nationalizing the ESAR-VHP Program	Missouri
Training and Situational Orientation	Texas
Recruitment and Health Volunteer Advocacy	Connecticut
Funding and Cost	Illinois
Data Definitions and Naming Conventions	Ohio
Operations and Maintenance	Massachusetts
Program Advisory Group Chair	Washington D.C.

From September 2004 to December 2004, representatives from 24 States participated in national working groups supporting the development of the Guidelines. Organizations participating in the national working groups include American Red Cross, Medical Reserve Corps, Joint Commission on Accreditation of Healthcare Organizations, American Nurses Association, American Medical Association, American Hospital Association, Centers for Disease Control and Prevention, and the American Association of Colleges of Nursing.



*State Participants in the National Working Groups*

## **1.6 Meeting ESAR-VHP Objectives**

The ESAR-VHP program is guided by four fundamental objectives to ensure the proper development and operation of each ESAR-VHP System. These objectives are:

- *Ensuring an Adequate and Competent Health Volunteer Force*
- *Enabling Efficient and Effective Emergency Operations*
- *Allowing Sharing of Health Volunteers Across State Lines*
- *Establishing Clear Protections for Health Volunteers, Hospitals, and Others*

The Guidelines are oriented to address these fundamental objectives.

## **1.7 Desired Outcome**

By the end of the program in December 2006, all States will have an ESAR-VHP System developed in coordination with HRSA's ESAR-VHP program, allowing for a national system of mutual assistance of health volunteers within a State's public health structures and hospital systems.

## **1.8 Organization of the Guidelines**

The Guidelines are organized into ten sections that correspond to the key topics confronting the States as they develop their ESAR-VHP Systems. In each section, the main issues identified by NBHPP community members are clearly described and appropriate recommendations or action items are provided.

At the beginning of each section there is a listing of required or recommended items for States to follow in support of proper ESAR-VHP System development. Each required or recommended item is explained in the section overview. At the end of each section, areas requiring additional research and examination are identified as Future Focus Areas. The Future Focus Areas will be addressed more substantively in future Guideline versions. In most cases, the Future Focus Areas are invitations for States to provide direct recommendations, suggestions, and potential solutions, which may be incorporated into future versions of the Guidelines.



## 2.0 Initial System Planning Activities

### 2.1 Overview of Initial System Planning Activities

This section describes the required and recommended initial items for States to take when planning the development of an ESAR-VHP System.

*Required items in this section:*

- 2.2 Assign an ESAR-VHP System Coordinator.

*Recommended items in this section:*

- 2.3 Form an ESAR-VHP program advisory group.
- 2.4 Review existing State approaches to initial system planning activities.

The following term is referenced in this section:

*ESAR-VHP System Coordinator* is a position responsible for overseeing, directing, or assisting in guiding the overall activities of the ESAR-VHP System, including coordinating System use in a declared emergency.

### 2.2 Assigning an ESAR-VHP System Coordinator

The Executive Director of the State Bioterrorism Preparedness and Response Program or other proper State authority will appoint the position of ESAR-VHP System Coordinator, referred to as the “System Coordinator.” The System Coordinator will be responsible for overseeing the planning, developing, and operations of the State ESAR-VHP System.

### 2.3 Forming an ESAR-VHP Program Advisory Group

An important first step in planning a successful ESAR-VHP program is establishing an advisory group. An advisory group assists with the State's efforts in planning for and building individual and organizational support and awareness of the ESAR-VHP program throughout the State. The advisory group may include representatives from organizations engaged in the State's ongoing public health and hospital disaster preparedness planning. These primary stakeholder groups may include, but are not limited to:

- State and local health departments and governments
- The hospital community (to include Veterans Affairs, public, and military hospitals)
- Red Cross, Medical Reserve Corps, and other volunteer organizations
- Emergency management agencies
- Emergency medical services providers
- Office of Rural Health
- Public and university health care providers
- Community health centers
- Bioterrorism and disaster preparedness training coordinators
- State and public health technology officers
- State licensing boards for health professionals

- State association for medical staff services
- Legal experts on the State's relevant legal and regulatory authorities and structures

### *2.3.1 Understanding Legal and Regulatory Issues*

It is essential to include individuals with expert knowledge of the State's legal and regulatory structures in areas such as State laws regarding emergency authorities, privacy, information collection, licensure, civil and criminal liability, workers' compensation, and System use. It is best to address legal and regulatory issues at the earliest stages of System planning. Not doing so will risk the viability of the ESAR-VHP System and may undermine the entire program. While legal issues are addressed briefly in relevant portions of these Guidelines, significant, additional information is available in the Legal and Regulatory Issues Report.

### *2.3.2 Using State-Issued Identification Cards*

If the ESAR-VHP System will be utilizing State-issued identification cards (ID cards), an advisory group should include the State's agency responsible for issuing identification cards, most likely the Department of Motor Vehicles (DMV). This should be done as early as possible to understand the technical and legal issues that need to be considered when developing an ESAR-VHP Program with the issuance of State-issued identification cards.

### *2.3.3 Assessing Technology and Systems Available in the State*

An advisory group should include the State's information technology staff in planning efforts to determine what systems the State may already have available to integrate with the ESAR-VHP System, such as professional licensure databases. The advisory group should create an inventory of potentially available systems to determine if any systems can be integrated, or converted for use with ESAR-VHP.

The level of coordination and consultation necessary among State stakeholders to define an acceptable and achievable model and to build support for the System's use will be extensive. Once the ESAR-VHP System planning activities are underway, the technical development of the ESAR-VHP System, with support of the ESAR-VHP Guidelines and ongoing Technical support, will be more easily facilitated.

### *2.3.4 Capturing Training Information*

An advisory group should include individuals responsible for overseeing bioterrorism and disaster preparedness training programs for a State's health volunteers. In particular, as training programs are being developed and training is being provided to health volunteers, the ESAR-VHP advisory group should examine how training information may be collected and recorded with the health volunteer's information on the ESAR-VHP System.

## 2.4 Overview of Ohio's Approach to ESAR-VHP System Planning



### Ohio Planning Activities for Ohio Volunteer Medical Response Corps (ESAR-VHP)

The planning of the Ohio ESAR-VHP System has been a long and challenging process. At the core of the ESAR-VHP efforts in Ohio is the establishment of the Ohio Volunteer Medical Response Corps (OVMRC). Establishing the ESAR-VHP System through the OVMRC has required extensive collaboration of many State agencies and professional organizations. Key stakeholders throughout the State have generously given time to establish the OVMRC because of the recognized need and because of the support the project gained at the highest level of State government.

#### *OVMRC Committee and Its Beginnings*

Following the events of Sept. 11, 2001, a large number of Ohio health care professionals spontaneously contacted their respective professional organizations to volunteer their services in Ohio in the event of a local or statewide emergency or disaster. This was not a recruitment effort, but rather a grass roots effort on the part of the Ohio health care professionals. The President of the Ohio State Medical Association spoke with J. Nick Baird, MD, Director of Health at the Ohio Department of Health (ODH), to discuss the role these prospective volunteers could perform during a local or statewide emergency. The Director of Health then reached out to other health care professional associations and found that the same phenomenon had occurred: large numbers of health care professionals in Ohio wanted to volunteer their services in the event of an emergency. Questions arose as to how these volunteers would be identified during an emergency and what was the most efficient and effective manner to use medical volunteers.

The Director of Health invited all of the Ohio health care professional associations and societies to participate in the newly formed Ohio Volunteer Medical Response Corps (OVMRC) Committee and endorsed it as a priority project. Over 20 State agencies, professional organizations, and the Ohio MRCs are represented on the Committee chaired by ODH. Physicians, psychiatrists, physician assistants, registered nurses, licensed practical nurses, pharmacists, pharmacy interns, psychologists, licensed independent social workers, licensed independent clinical counselors, dentists, and EMS professionals are the first groups of medical volunteers that the OVMRC Committee deemed necessary for fulfilling personnel surge capacity needs. Other specialties may be added later.

The OVMRC Committee has met regularly since April 2002 to coordinate medical volunteer efforts throughout the State. The committee's purpose is to facilitate State, regional, and local preparedness by developing consistent, statewide parameters to assist in the deployment of physicians and other health care professional volunteers. These parameters include credentialing and training volunteers as well as identifying and resolving legal and other issues. The committee reports to the Director of Health who is a member of the State of Ohio Security Task Force (SOSTF). The SOSTF, established by Governor Bob Taft and chaired by a member of the

cabinet, has the primary task of developing a coordinated, comprehensive strategy to address security issues.

The Committee originally planned to establish a database and issue volunteer photo identification cards using the services of the Ohio Bureau of Motor Vehicles, but found later that this was not feasible. When the Committee learned that the Ohio Citizen Corps (OCC), a project of the Ohio Community Service Council (OCSC), already developed a database and training activities, the Committee decided not to duplicate these activities and recommended health care professional volunteers (OVMRC) be linked and highly integrated with OCC activities and databases. It also recommended linking OVMRC credentialing activities to training initiatives and integrating them with the OCC, state professional licensing boards, associations, and agencies. These recommendations and the steps a volunteer needs to complete, known as "Process to Volunteer," were presented to the SOSTF in February 2004. Implementation of these recommendations is ongoing.

### *Legal and Regulatory Issues*

The Committee recognized early in the development of OVMRC that there were significant legal issues for health care volunteers in Ohio and continues to investigate Ohio's legal and regulatory environment. Legal issues considered by the Committee include the confidentiality of information on the OCC database and the application of civil liability to health volunteers during an emergency. Attorneys from the Ohio Department of Health, the Ohio Community Service Council, and the Ohio Emergency Management Agency met several times in spring 2004 to discuss the issues, to review the laws regarding volunteers, and to draft legislation to address these concerns. The legislation has been reviewed by the directors of the three agencies and now is under review by the Governor's Office.

### *Ongoing Efforts*

In spring 2004, OCC Council formed a Notification and Mobilization Task Force to address all issues surrounding mobilization and coordination for all Ohio volunteers including those in OVMRC. The newly formed Task Force consists of other OCC programs such as Community Emergency Response Teams (CERT) and Volunteers in Police Program (VIP) and State and local agencies. The Task Force recommended the development of the concept for a Volunteer Reception Center and recommended using an identification card that all volunteers, including the OVMRC, will carry to deployment. The Volunteer Reception Center concept is in development and will include hospital representation to develop credentialing elements needed for hospital surge capacity. All of these efforts serve to facilitate State, regional and local preparedness by developing consistent, statewide parameters to assist in volunteer deployment. The Committee will be working with the OCC Communications Office to develop recruiting materials for the OVMRC. This is an effort not to duplicate services and information.

Contributors are listed in Appendix 2.

## 3.0 System Design

### 3.1 Overview of System Design

This section describes required and recommended items for addressing the three elements of system design for the ESAR-VHP Systems. The three elements are System Functions, System Content, and System Architecture.

*Required items in this section:*

- 3.2 Design the ESAR-VHP System to perform three distinct functions:
  - 3.2.1 Registration.
  - 3.2.2 Emergency Credentialing.
  - 3.2.3 Emergency Verification.
- 3.3 Collect the necessary information to allow for System functions to operate:
  - 3.3.1 Health Volunteer Authorizations and Acknowledgements.
  - 3.3.2 Identification Information.
  - 3.3.3 Credentialing Information.

*Recommended items in this section:*

- 3.4 Review System architecture information.
- 3.5 Review future focus of the ESAR-VHP program related to System design issues.

The following terms are referenced in this section:

*System Functions* are the essential activities performed by an ESAR-VHP System.

*System Content* consists of the information elements needed for each of the System functions to perform properly.

*System Architecture* relates to the high-level network approaches available to a State assembling an ESAR-VHP System, or how the ESAR-VHP System functions are put together.

Throughout this section and the document, the capitalized words “System” and “Systems” refer specifically to a State ESAR-VHP System. The lower case words “system” and “systems” refer to other systems.

### 3.2 Three Primary Functions of the ESAR-VHP System

The ESAR-VHP System must be designed to support three interdependent, interoperable functions. These three functions are as follows:

1. *Registration* records health volunteer information with proper health volunteer authorizations.
2. *Emergency Credentialing* assigns each health volunteer an emergency credentialing level in accordance with emergency credentialing standards based on credential information inputs.

3. *Emergency Verification* verifies the health volunteer information and authorizes the information's use in an emergency.

These three functions must be integrated because the information requirements of each function are interdependent. Additionally, each function must be performed in a secure manner with close consideration given to privacy issues, as described in the Security and Privacy section. States should ensure that the acquisition, use, disclosure, and storage of personally identifiable information are all consistent with federal and State information privacy laws. A description of each function follows.

#### 3.2.1 *Registration*

The first function of an ESAR-VHP System is the registration of health professionals willing to volunteer health services in an emergency. By registering in the System, the volunteer agrees to be considered to provide volunteer health services during an emergency and has also authorized the State to collect the information necessary to determine that individual's credential status and emergency credentialing level. The information collected to support the registration function is described in the System Content portion of this section. Emergency credentialing standards are described in the Emergency Credentialing Standards section.

Registering health volunteers, assigning emergency credentialing levels, and verifying credential information may be performed in a variety of ways. For example, ESAR-VHP registration may be performed in cooperation with existing membership registration processes used by volunteer organizations such as the Medical Reserve Corps, or other State recognized volunteer organizations. However, a State must aggregate all registration information into a central database containing required registration information for all of the State's health volunteers in order to perform the additional required functions of emergency credentialing and emergency verification.

#### 3.2.2 *Emergency Credentialing*

Emergency credentialing is the process of collecting the health volunteer's credential information, processing the information, and assigning an emergency credentialing level according to the emergency credentialing standards provided in the Guidelines. Credential information, also known as credential elements, is used in assigning emergency credentialing levels. The emergency credentialing standards established under the ESAR-VHP Program are designed to facilitate the orderly management and coordination of resources in an emergency. Descriptions of the emergency credentialing standards can be found in the section entitled Emergency Credentialing Standards. Emergency credentialing levels for health volunteers are designed to help the delegated authorities determine how to utilize the services of a health volunteer.

The assignment of an emergency credentialing level to a health volunteer neither designates clinical privileges for the health volunteer nor does it authorize the health volunteer to provide health services without proper authorization and supervision. The assignment of clinical privileges is the responsibility of the hospital authority or other appropriate authority utilizing the health volunteer.

At a minimum, the System must be able to determine if the health volunteer has an active professional license in the profession or discipline for which he or she is practicing. In order to do so, access to State licensing databases or direct coordination with State licensing authorities is necessary. State legal authorities should be consulted to determine whether a health volunteer will be eligible to practice across State lines, and in which States such practice is authorized. For a discussion of the legal implications of practicing across State lines, refer to section 3.2 of the Legal and Regulatory Issues Report.

Further discussion of the role of external databases in applying emergency credentialing standards and considerations and approaches to integrating these elements into a System can be found in the Emergency Credentialing Standards section.

### *3.2.3 Emergency Verification*

The last essential System function is the ability for delegated authorities to access and verify a health volunteer's information in an emergency. The health volunteer's information is stored in a System as a health volunteer record. The health volunteer's record is the complete set of information maintained on the health volunteer by the System. Information from the health volunteer record, in some form, must be accessible to perform emergency verifications of health volunteer information.

When planning a System, States should define protocols on how entities are to support the coordination of health volunteers and how to validate the information of health volunteers as they check-in to an emergency. Specifically, the State will need to clearly define and communicate who has the authority to dispatch the health volunteer based on System information.

Any electronic communications passed over shared lines should be encrypted to prevent accidental release of data. Furthermore, appropriate security precautions, such as firewalls, should exist between the System and any entity with access to health volunteer information. It is recommended that information be transmitted in digital form so that an audit trail is established, and information is provided in a form that may be utilized by a wide number of receiving individuals. In being able to access and review information from multiple authorized locations, the Internet is the most flexible, prevalent, and effective network to accommodate the functioning of the System.

When a dispatched health volunteer checks-in at an emergency staging area, the receiving entity then must be able to verify information about the volunteer, such as identity, credential information, and emergency credentialing level. Some of the information may be available on an ID card, through a networked System, or by other means. In all cases, efforts should be made to access the most currently available information from the System when verifying a health volunteer's information. The System must provide the capability to verify a health volunteer's identity and necessary information with the most current information available on the System. At a minimum, an authorized party should be able to ascertain from the ID card, then verify, electronically, if possible, a health volunteer's identity, emergency credentialing level, and credential information in an easily understood format.

In general, all decisions to dispatch health volunteers during an emergency should be made in accordance with the State's formal emergency response plan and incident command structure. If the System is to be used in non-State emergencies, State and local authorities will need to establish clear protocols on System access and use. For example, if access rights to the System are not clearly defined or responsibilities to dispatch and command health volunteers are not clear, a receiving entity with System information, such as a hospital, may make decisions to put health volunteers into service without coordinating the request through appropriate authorities. Such an action would bypass the established incident command structure and may jeopardize the legal and liability protections provided by the State to institutions and health volunteers during a declared emergency. For a discussion of the legal consequences of bypassing state authorities in an emergency, refer to section 3.3 of the Legal and Regulatory Issues Report.

In addition, access to the electronic System assumes that technological systems are functioning during the emergency. In addition to technological capabilities, manual capabilities should be developed for redundancy and back-up options in the event that technology systems are not available. Manual systems include State issued identification cards carried by health volunteers, paper reports of System records, or freestanding System back-ups. Further information on back-up systems is provided in the System Operations and Maintenance section.

Additional discussion of the means and processes of identifying and authenticating health volunteer information are found in the Emergency Credentialing Standards and Security and Privacy, and Data Definitions sections.

### **3.3 Collecting the Necessary Information to Allow for System Functions**

System content describes the information elements that the System must collect to meet the three functional requirements described in the System Design section. These information elements reside in three data groups:

1. Health Volunteer Authorizations and Acknowledgements
2. Identification Information
3. Credential Information

Each key data set and associated information elements are presented here with a minimal level of detail. In-depth descriptions of each key data set and suggestions for information elements are found in the Data Definitions section and other sections of the Guidelines.

#### *3.3.1 Health Volunteer Authorizations and Acknowledgements*

The information elements defined in this data set include authorizations and acknowledgements given by the health volunteer to the ESAR-VHP System to collect and maintain his or her information. The information collected in this data set is imperative to supporting the System Registration function. Information includes:

- Consent for the State to collect, use, and maintain the health volunteer's personal information

- Specific preferences for health volunteer service, with a minimum indication of geographic limits: local, State, out-of-state and time commitments
- Indication of willingness to work under the auspices of the U.S. Federal Government during the time of a national emergency
- A pledge to provide accurate information
- The date each of the above actions were specified

### *3.3.2 Identification Information*

The information elements defined in this data set are used to verify a registrant's identity for helping to collect and verify additional credentialing information, to facilitate identification and check-in at an emergency staging, and emergency verification. Information elements in this data set include:

- Legal Name
- Legal Residence
- State assigned unique ESAR-VHP health volunteer number

A color photograph from a State issued driver's license or identification card or other State or federally accepted identification card is essential to assist in verifying identities of a health responder at an emergency check-in. A number of additional information elements may be collected, based on the particular needs of the State. Further specifications and examples of identification information are found in the Data Definitions section.

### *3.3.3 Credential Information*

The information elements defined in this data set, used to determine a health volunteer's emergency credentialing level, may include relevant education, professional training, licensure, certification, and clinical practice information. Once the health volunteer authorizations and acknowledgements and identification information data sets are collected and the credential information data set is complete, an emergency credentialing level may be assigned based on the emergency credentialing standards methodology found in the Emergency Credentialing Standards section of the Guidelines.

## **3.4 System Architecture**

System Architecture refers to the composition of systems and technologies used to perform the required System functions of registration, emergency credentialing, and emergency verification. There are a wide range of options for how the overall System may be composed to properly perform the required functions. Because the System functions are interdependent and interoperable, technologies and processes to transfer information between functions must be fully integrated and securely performed.

A System must utilize both technological and manual processes to perform and integrate System functions seamlessly. During the Guidelines testing period, existing State System architectures will be evaluated to determine effective practices which may be shared nationally across States.

Emphasis will initially be placed on analyzing State Systems from Connecticut, Ohio, Minnesota, Missouri, West Virginia, and Wisconsin.

The following processes already in use or being considered to support System functions will be evaluated.

Registration:

- Web-based registration and account maintenance
- Integration with professional license renewal
- Paper-based registration
- Hospital administered registration

Emergency Credentialing:

- Integration with State licensing databases
- Manual verification of licensure information
- Verification of credentials through credential verification organization
- Verification of credentials from participating hospital

Emergency Verification:

- Web-based information confirmation
- Smart Card technology
- Static ID cards
- Telephone and wireless verification
- Hard copy volunteer directory back-ups
- Localized database access on PCs

### **3.5 Future Focus Areas and Needs of the National ESAR-VHP Project**

- Determine the appropriate data standards and methods to link together disparate intrastate networks.
- Evaluate System architectures from State models in development phase to assist in the development of peer State System architectures.
- Determine appropriate model for coordinating System design implementations to ensure capability to utilize health volunteers across State lines.

## 4.0 Emergency Credentialing Standards

### 4.1 Overview of Emergency Credentialing Standards

This section describes the required and recommended items for applying ESAR-VHP emergency credentialing standards. All emergency credentialing standards provided in this section will be evaluated during the Guidelines testing period, which concludes in June 2005.

ESAR-VHP emergency credentialing standards will be updated, revised, and expanded as needed. All State Systems will be required to classify health volunteers in accordance with the emergency credentialing standards. The timeline for implementation of emergency credentialing standards with the ESAR-VHP System will be determined during the Guidelines testing period.

*Required items in this section:*

- 4.2 Review the classification of health volunteers according to the emergency credentialing standards.
- 4.3 Implement emergency credentialing standards for physicians.
- 4.4 Implement emergency credentialing standards for registered nurses.
- 4.5 Implement emergency credentialing standards for marriage and family therapists.
- 4.6 Implement emergency credentialing standards for medical and public health social workers.
- 4.7 Implement emergency credentialing standards for mental health and substance abuse social workers.
- 4.8 Implement emergency credentialing standards for psychologists.
- 4.9 Implement emergency credentialing standards for mental health counselors.
- 4.10 Review notes on emergency credentialing standards for behavioral health professionals.
- 4.11 Determine the level of information needed for emergency credentialing standards.

*Recommended items in this section:*

- 4.12 Review information on privileging of health volunteers.
- 4.13 Review existing State approach to emergency credentialing standards with the ESAR-VHP Program.

The following terms and emergency credentialing standards definitions will be referenced in this section:

*Credentials* are a health volunteer's qualifications. Credentials are used with an ESAR-VHP System to determine a health volunteer's Emergency Credential Level. According to JCAHO, credentials are the documented evidence of licensure, education, training experience, or other qualifications.<sup>1</sup>

*Credentialing* is the process of obtaining, verifying, and assessing the qualifications of a health care professional to provide patient care, treatment, and services in or for a health care organization.

*Privileging* is the authorization granted by the health care entity for a qualified health professional to provide patient care, treatment, and services with or without supervision. Privileging is performed on a case-by-case basis and the responsibility for assigning privileges resides with the entity that receives volunteers in response to an emergency.

*Primary source* is the original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care professional.

*Primary source verification* is the direct verification of a health care professional's credential(s) by the entity that issued the credential or by means of a Credential Verification Organization (CVO), or a Joint Commission for the Accreditation of Health Care Organizations (JCAHO) designated equivalent source. The term *verify* used in this section will refer to primary source verification unless noted otherwise.

*Indeterminate* describes a credential that is not verified, and therefore, may or may not be possessed by the health volunteer.

*Emergency Credentialing Standards* are a taxonomy intended to promote interoperability and integration of medical and health personnel commonly needed in an emergency response. Within the ESAR-VHP program, the application of emergency credentialing standards is a uniform process of classifying a health volunteer into an emergency credentialing level based on verified credentials possessed by the health volunteer.

*Emergency Credentialing Level* is a designation assigned to a health volunteer registered in an ESAR-VHP System based on possessed and verified credentials, as defined by emergency credentialing standards. The highest emergency credential level is 1 and indicates that the health volunteer possesses all of the minimum required credentials and that the credentials have been appropriately verified.

#### **4.2 Classifying Health Volunteers According to the Emergency Credentialing Standards**

Emergency credentialing standards establish common personnel resource definitions that help make ordering and dispatching personnel during an incident more efficient and that ensure authorities receive the personnel they need during an emergency or disaster. A limited set of credentials are utilized under the emergency credentialing standards. Additional information on the qualifications of a health volunteer to provide health services in a disaster, such as disaster preparedness training or specialized professional experience, may also be collected by an ESAR-VHP System and utilized by States. Definitions for additional qualifications that may be collected by an ESAR-VHP System to supplement the minimum credential information requirements of emergency credentialing standards are presently being determined and will be provided in future versions of the Guidelines.

HRSA will ensure that the emergency credentialing standards are properly established and implemented for medical and health personnel by States as part of the ESAR-VHP program. With successful development of emergency credentialing standards for health professionals during the Guidelines testing period, emergency credentialing standards for the ESAR-VHP Systems will become the standard for the ESAR-VHP program. Each health volunteer registered

in an ESAR-VHP System will be classified by emergency credentialing level, in accordance with emergency credentialing standards.

The emergency credentialing standards are based on a standard interpretation of credential elements. Under the emergency credentialing standards, the emergency credentialing level Protocol classifies personnel resources using a systematic methodology. The classification terminology to be used is as follows:

*Metrics* are the measurement standards used when determining emergency credentialing levels for health volunteers. For the ESAR-VHP program, the metrics for determining an emergency credentialing level is the verification of a defined set of credential elements. Credential elements used for emergency credentialing standards will vary according to occupation.

*Occupation* is the class that characterizes personnel resources. For the ESAR-VHP program, occupations will be professional disciplines, based on established industry definitions. Classifications of occupations will correspond to Standard Occupational Classification codes (SOC). Initial occupations covered in the Guidelines are registered nurses, physicians, and the behavioral health professions of psychologists, marriage and family therapists, medical and public health social workers, mental health and substance abuse social workers, and mental health counselors.

*Emergency Credentialing Level* is defined by the verification of credential elements according to Emergency Credentialing Standards. Each occupation will utilize a similar emergency credentialing level methodology with varying metrics. Emergency credentialing standards are provided and will be evaluated and refined as needed during the Guidelines testing period for physicians, registered nurses, marriage and family therapists, medical and public health social workers, mental health and substance abuse social workers, psychologists, and mental health counselors. Initially, each health profession being evaluated will have up to four emergency credentialing level classifications: Levels 1, 2, 3, and 4.

Summary of emergency credentialing standards conventions for the ESAR-VHP program:

<i>Metric:</i>	Verification of credential elements, as defined by the ESAR-VHP program.
<i>Occupation:</i>	Health profession occupations utilizing Standard Occupational Classification codes (SOC) for basic health profession definitions.
<i>Emergency Credentialing Level:</i>	Up to four Levels (1, 2, 3, and 4) are based on the possessed and verified credentials for each health volunteer initially registered

#### *4.2.1 Credential Elements and Emergency Credentialing Standards*

The verification of credentials serve as the metrics used to set a health volunteer's emergency credentialing level ("Level"). The specific credentials used as metrics to determine a health volunteer's emergency credentialing level will vary according to occupation. Each occupation has a uniform set of credential elements to be both collected and verified. To ensure that health volunteers registered in an ESAR-VHP System are uniformly assigned emergency credentialing levels across States, each State System must assign emergency credentialing levels according to the emergency credentialing methodology provided by the ESAR-VHP program.

For each occupation, the ESAR-VHP emergency credentialing methodology may have up to four (4) emergency credentialing levels. By convention, an emergency credentialing Level 1 will possess all specified verified credential elements for the occupation. An emergency credentialing Level 2 will possess fewer verified credential elements. The same process is utilized for all occupations.

If a health volunteer's credential element is not verified, the credential element is considered indeterminate.

#### *4.2.2 Approach to Developing and Presenting Emergency Credentialing Standards*

During the Guidelines testing period, the emergency credentialing standards definitions for a limited number of occupations will be evaluated. The occupations include physicians, registered nurses, marriage and family therapists, medical and public health social workers, mental health and substance abuse social workers, psychologists, and mental health counselors. Emergency credentialing standards definitions for each occupation listed above are provided in this section.

For each occupation, there is a description of the credentialing and metric verification process, explanation of credential elements and metrics used to set emergency credentialing levels, and, if applicable, additional emergency credentialing standards information. Information for behavioral health volunteers follows the definitions for mental health counselor's emergency credentialing levels.

Prior to becoming a formal System requirement, each emergency credentialing standards definition introduced in this section will be evaluated during the Guidelines testing period. Each emergency credentialing standards definition will be updated, revised, and expanded as needed.

The next version of the Guidelines will include the emergency credentialing standards for the following high priority occupations:

- Advanced Practice Nurses (Nurse Practitioners, Nurse Anesthetists, Certified Nurse Midwives, and Clinical Nurses Specialists)
- Physician Assistants
- Dentists
- Emergency Medical Technicians (EMTs) and Paramedics
- Pharmacists
- Licensed Practical Nurses

- Respiratory Therapists
- Respiratory Therapy Technician
- Cardiovascular Technologist and Technicians
- Radiologic Technologists & Technicians
- Surgical Technologists
- Medical and Clinical Laboratory Technologists
- Medical and Clinical Laboratory Technicians (includes Phlebotomists)
- Diagnostic Medical Sonographers
- Veterinarians

After the addition of these priority occupations, subsequent versions will include additional occupations. Ultimately, the Guidelines will include Emergency Credentialing Standards for approximately 65 health and health related occupations.

### **4.3 Emergency Credentialing Standards for Physicians**

A *physician* is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who, by virtue of education, training, and demonstrated competence, is fully licensed to practice medicine and may be granted clinical privileges by a health care organization to perform specific diagnostic or therapeutic procedures.

Metrics consist of the verification of credential elements consisting of Degree, Unencumbered License, Board Certification, Active Clinical Privileges, and Active Clinical Practice along with the inquiry of the National Practitioner Database Status, DEA License verification, and Inspector General Status.

A Physician, for the purposes of emergency credentialing standards, is considered to possess a credential element only if the credential element is properly verified. The status for the credential element will either be verified, indeterminate, or not required in the case of Active Clinical Practice for Level 1 classification. An indeterminate status describes a credential element that is not verified; therefore, the credential element may or may not be possessed by the health volunteer.

Supporting materials that describe emergency credentialing standards for physicians included in this section of the Guidelines are:

- 4.3.1 Credential Verifications for Applying Emergency Credentialing Standards for Physicians
- 4.3.2 Explanation of Credential Elements for Emergency Credentialing Levels for Physicians
- 4.3.3 Notes on the Applying Emergency Credentialing Standards for Physicians
- 4.3.4 Designated Equivalent Sources for Credential Information for Physicians

*4.3.1 Credential Verifications for Applying Emergency Credentialing Standards for Physicians*

<b>Physician Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification—ABMS/AOA Specialty & Subspecialty	Verified
Active Clinical Practice	Not Required
Active Clinical (Hospital) Privileges	Verified
National Practitioner Databank Status	Verified
DEA License	Verified
Inspector General Status	Verified

<b>Physician Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification—ABMS/AOA Specialty & Subspecialty	Verified
Active Clinical Practice	Verified
Active Clinical (Hospital) Privileges	Indeterminate
National Practitioner Databank Status	Verified
DEA License Verification	Verified
Inspector General Status	Verified

<b>Physician Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Indeterminate
Certification—ABMS/AOA Specialty & Subspecialty	Indeterminate
Active Clinical Practice	Indeterminate
Active Clinical (Hospital) Privileges	Indeterminate
National Practitioner Databank Status	Indeterminate
DEA License Verification	Indeterminate
Inspector General Status	Indeterminate

<b>Physician Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree	Indeterminate
Certification—ABMS/AOA Specialty & Subspecialty	Indeterminate
Active Clinical Practice	Indeterminate
Active Clinical (Hospital) Privileges	Indeterminate
National Practitioner Databank Status	Indeterminate
DEA License Verification	Indeterminate
Inspector General Status	Indeterminate

#### 4.3.2 Explanation of Credential Elements for Emergency Credentialing Levels for Physicians

Credential Element	Evidence of Credential	Verification Mechanism
<p><i>Degree</i> Academic title conferred by universities and colleges as an indication of the completion of a course of study in medicine.</p>	<p>Possesses a valid M.D. or D.O. degree from an educational institution accredited by the American Association of Medical Colleges (AAMC) or the American Osteopathic Association (AOA). Graduates from foreign medical schools will possess verification of graduation from the Educational Commission for Foreign Medical Graduates (ECFMG).</p>	<p>Primary source verification or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.</p>
<p><i>Unencumbered License</i> A State issued active medical license that has no restrictions.</p>	<p>Possesses current unencumbered medical license</p>	<p>Primary source verification (State licensing board) or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.</p>
<p><i>ABMS/AOA Board Certification</i> A formal certification recognizing a physician has completed specialty or subspecialty training and has passed a certifying examination from a specialty organization recognized by the American Board of Medical specialties (ABMS) or the American Osteopathic Association (AOA).  A detailed table on ABMS certifications is provided in the Data Definitions section of the Guidelines.</p>	<p>Possesses Board Certification from ABMS/AOA recognized specialty or sub-specialty.</p>	<p>Primary source verification or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.</p>

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<i>Active Clinical Practice</i> Active practice of medicine in the provision of direct patient care.	Physician has current practice in a hospital or non-hospital setting.	Attestation or other documentation from the entity where the physician is practicing or peer reference affirming the physician is actively practicing medicine in a hospital or non-hospital setting.
<i>Active Clinical (Hospital) Privileges</i> Privileges to work in a hospital setting.	Physician has current hospital privileges.	Attestation or other documentation from the entity where the physician is practicing or peer reference affirming the physician is actively practicing medicine and has privileges in a hospital setting.
<i>National Practitioner Databank Status</i>	Physician does not have an active disciplinary issue in any jurisdiction.	Primary source verification or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.
<i>DEA License Verification</i>	Physician has a DEA License.	Primary source verification or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.
<i>Inspector General Status</i>	Physician does not have an active sanction in any jurisdiction.	Primary source verification or delegation to a JCAHO accredited organization that has performed primary source verification of the volunteer's credentials.

#### *4.3.3 Notes on Applying Emergency Credentialing Standards for Physicians*

For emergency credentialing Level 4, all credential elements are indeterminate. A State may classify unlicensed physicians, which include retired physicians without an active license, medical and osteopathic students, and physicians who have not had credentials appropriately verified as Level 4 physicians.

For credential verifications, the accepted standard for verifying physician credentials is termed primary source verification. Primary source verification occurs when a source that grants a specific credential to a physician also verifies that the physician has received that credential. There is a variety of methods for accomplishing primary source verification. The first is to perform all verifications independently with the primary source for each credential. The second is to use a CVO to perform the verifications for the ESAR-VHP System. The CVO can verify one credential, several or all credentials depending on the services the CVO offers. There are many CVOs in existence and, typically, a fee is charged for using the services offered.

There are circumstances when direct primary source verification is impractical. In such circumstances, JCAHO allows primary source verification by using a “designated equivalent source”. Such a source substitutes for performing a direct primary source and is an acceptable alternative. A table listing the Designated Equivalent Source and the credential element able to be verified is included later in this section.

The last method for accomplishing primary source verification determined acceptable for the purposes of an ESAR-VHP System is to delegate primary source verification to a JCAHO accredited facility provided the facility has performed all the necessary primary source verifications as part of their internal processes. In effect, the facility is functioning as a CVO on behalf of the ESAR-VHP System.

Ensuring proper licensure and credentialing in establishing the appropriate emergency credentialing levels has legal implications for health volunteers and hospitals utilizing their services. A discussion of the legal requirements for licensure, credentialing, and privileging is available at section 3.2 of the Legal and Regulatory Issues Report. Section 3.3 of the Legal and Regulatory Issues Report addresses the civil liability.

#### 4.3.4 Designated Equivalent Sources for Credential Information for Physicians

Agency	Agency Source	Credential Element(s)
AMA	Physician Masterfile	Medical School Graduation Residency completion
ABMS		Physician Board Certification
ECFMG		Physician graduation from foreign medical school
AOA	Physician Database for pre- doctoral education	Physician graduation from AOA accredited school of
AOA	Council on Postdoctoral Training	Osteopathic residency completion
AOA	Osteopathic Specialty Board Certification	Osteopathic Board Certification
FSMB		Actions against a physician's medical license

Selected agencies that have been determined to maintain a specific item or items of credential information that is identical to the information at the primary source.<sup>2</sup>

#### 4.4 Emergency Credentialing Standards for Registered Nurses

A *registered nurse* (RN) has passed a State registration examination and has been licensed to practice as a registered nurse. The registration license is intended to ensure minimum levels of competence and thus protect the public, not to indicate the educational background of a nurse.<sup>3</sup>

Metrics include the verification of credential elements consisting of Degree or Diploma, Unencumbered License, Certification, and Active Clinical Practice.

A registered nurse, for the purposes of establishing emergency credentialing standards is considered to possess a credential element only if the credential element is properly verified. The status for the credential element will be either verified or indeterminate. An indeterminate status describes a credential element that is not verified; therefore, the credential may or may not be possessed by the health volunteer.

Supporting materials that describe emergency credentialing standards for registered nurses included in this section of the Guidelines are:

- 4.4.1 Credential Verifications for Applying Emergency Credentialing Standards for Registered Nurses
- 4.4.2 Explanation of Credential Elements for Emergency Credentialing Levels for Registered Nurses
- 4.4.3 Notes on Applying Emergency Credentialing Standards for Registered Nurses

#### 4.4.1 Credential Verifications for Applying Emergency Credentialing Standards for Registered Nurses

Registered Nurse Level 1	Status
Unencumbered License	Verified
Degree/Diploma	Verified
Certification	Verified
Active Clinical Practice	Verified

Registered Nurse Level 2	Status
Unencumbered License	Verified
Degree/Diploma	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

Registered Nurse Level 3	Status
Unencumbered License	Verified
Degree/Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

Registered Nurse Level 4	Status
Unencumbered License	Indeterminate
Degree/Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

#### 4.4.2 Explanation of Credential Elements for Emergency Credentialing Levels for Registered Nurses

Credential Element	Evidence of Credential	Verification Mechanism
<p><i>Degree</i> An academic degree awarded in nursing that is sufficient to meet the licensing requirements to become a registered nurse.</p> <p>or</p> <p><i>Diploma</i> A certificate awarded by a hospital based program that trains registered nurses that is sufficient to meet the licensing requirements to become a registered nurse.</p>	Possesses a valid RN degree from an accredited nursing school or possesses a valid Nursing Diploma from a hospital-based program.	Primary source verification or verification performed by a process acceptable to a JCAHO accredited healthcare organization or by a JCAHO accredited healthcare organization.

Credential Element	Evidence of Credential	Verification Mechanism
<i>Unencumbered License</i> An active license to practice as a registered nurse within the State's scope of practice for a registered nurse.	Possesses a valid nursing license without restrictions.	Primary source verification or verification performed by a process acceptable to a JCAHO accredited healthcare organization or by a JCAHO accredited healthcare organization.
<i>Certification</i> A formal document that recognizes that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.	Possesses current certification.	Primary source verification or verification performed by a process acceptable to a JCAHO accredited healthcare organization or by a JCAHO accredited healthcare organization.
<i>Active Clinical Practice</i> Currently involved in the provision of direct patient care.	Currently engaged in the practice of nursing.	Primary source verification or verification performed by a process acceptable to a JCAHO accredited healthcare organization or by a JCAHO accredited healthcare organization.

#### 4.4.3 Notes on Applying Emergency Credentialing Standards for Registered Nurses

Registered Nurses typically are not granted privileges; rather they are employed by a hospital or other health care organization and work within a scope of practice as permitted by the State licensing agency. This distinction is important in the context of professional liability because the employer may become responsible for any negligent acts committed by an employee nurse. For a complete discussion of the liability issues surrounding the employment of nurses, refer to section 3.3 of the Legal and Regulatory Issues Report.

In keeping with the JCAHO non-emergency standard regarding credential verification, registered nurse credentials can be considered verified by true primary source verification, as already described, or by usual practices for doing so by a JCAHO accredited organization. The Comprehensive Accreditation Manual for Hospitals, *The Official Handbook* JCAHO 2004 states, "The hospital verifies the following according to law, regulation and hospital policy: current licensure, certification, or registration."<sup>4</sup>

Primary source verification is possible by national entities for nursing licenses and for primary source verification of nursing certificates. State regulations must be reviewed to determine what types of verifications are acceptable. Furthermore, State law should be reviewed to determine the appropriate scope of practice based on the type of license possessed and any relevant specialty certification.

#### 4.5 Emergency Credentialing Standards for Marriage and Family Therapists

A *marriage and family therapist* (MFT) is a mental health professional who is trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family systems. Marriage and Family Therapists have graduate training (a Master's or Doctoral degree) in marriage and family therapy and at least two years of clinical experience.<sup>5</sup>

Metrics include the verification of credential elements consisting of Degree, Unencumbered License, Certification, and Active Clinical Practice.

Supporting materials that describe emergency credentialing standards for marriage and family therapists included in this section of the Guidelines are:

- 4.5.1 Credential Verifications for Applying Emergency Credentialing Standards for Marriage and Family Therapists
- 4.5.2 Explanation of Credential Elements for Emergency Credentialing Levels for Marriage and Family Therapists

##### 4.5.1 *Credential Verifications for Applying Emergency Credentialing Standards for Marriage and Family Therapists*

<b>MFT Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification	Verified
Active Clinical Practice	Verified

<b>MFT Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MFT Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MFT Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

#### 4.5.2 Explanation of Credential Elements for Emergency Credentialing Levels for Marriage and Family Therapists

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<i>Unencumbered License</i> An active and unrestricted State issued license.	Possesses a current unencumbered license, as applicable, in Marriage and Family Therapy.	Verified with the issuing State agency as applicable.
<i>Degree</i> Academic title conferred by universities and colleges as an indication of the completion of a course of study.	Possesses a degree in Marriage and Family Therapy from an accredited university or college.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Certification</i> A formal document that recognizes that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.	Possesses a document awarded by the National Board of Certified Counselors evidencing successful completion of the requirements of one of its specialty boards.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Active Clinical Practice</i> Evidence that the health volunteer is currently engaged in the practice of Marriage and Family Therapy within the scope of their license (if required by the State).	Volunteer is actively practicing as a Marriage and Family Therapist.	Attestation or other documentation from the entity where the volunteer is working or peer reference affirming the volunteer is actively working as a Marriage and Family Therapist.

#### 4.6 Emergency Credentialing Standards for Medical and Public Health Social Workers

*Medical and public health social workers* (MPHSW) provide persons, families, or vulnerable populations with the psychosocial support needed to cope with chronic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, or AIDS. They also advise family caregivers, counsel patients, and help plan for patients' needs after discharge by arranging for at-home services from Meals-on-Wheels to oxygen equipment. Some work on interdisciplinary teams that evaluate certain kinds of patients, for example, geriatric or organ transplant patients. Medical and public health social workers may work for hospitals, nursing and personal care facilities, individual and family services agencies, or local governments.<sup>6</sup>

Metrics include the verification of credential elements consisting of Degree or Diploma, Unencumbered License, Certification, Active Clinical Practice.

Supporting materials that describe emergency credentialing standards for medical and public health social workers included in this section of the Guidelines are:

- 4.6.1 Credential Verifications for Applying Emergency Credentialing Standards for Medical and Public Health Social Worker
- 4.6.2 Explanation of Credential Elements for Emergency Credentialing Levels for Medical and Public Health Social Workers

*4.6.1 Credential Verifications for Applying Emergency Credentialing Standards for Medical and Public Health Social Workers*

<b>MPHSW Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Verified
Active Clinical Practice	Verified

<b>MPHSW Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MPHSW Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MPHSW Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

#### 4.6.2 Explanation of Credential Elements for Emergency Credentialing Levels for Medical and Public Health Social Workers

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<i>Unencumbered License</i> An active and unrestricted State issued license.	Possesses a current unencumbered license, as applicable, in Social Work.	Verified with applicable State agency.
<i>Degree</i> Academic title conferred by universities and colleges as an indication of the completion of a course of study.	Possesses an acceptable degree in Social Work from an accredited university or college.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Certification</i> A formal document that recognizes that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.	A document awarded by the Association of Social Work Boards evidencing successful completion of the requirements as a Health Care Social Worker.	Verified with the Association of Social Work Boards or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Active Clinical Practice</i> Active practice within the chosen profession.	The volunteer has an active clinical practice in Medical and Public Health Social Work.	Attestation or documentation from the entity where the individual is practicing confirming active practice or a peer reference affirming the individual is actively practicing within the profession.

#### 4.7 Emergency Credentialing Standards for Mental Health and Substance Abuse Social Workers

*Mental health and substance abuse social workers* (MHSASW) assess and treat individuals with mental illness, or substance abuse problems, including abuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They may also help plan for supportive services to ease patients' return to the community. Mental health and substance abuse social workers are likely to work in hospitals, substance abuse treatment centers, individual and family services agencies, or local governments. These social workers may be known as clinical social workers.<sup>7</sup>

Metrics include the verification of credential elements consisting of Degree or Diploma, Unencumbered License, Certification, and Active Clinical Practice.

Supporting materials to describe emergency credentialing standards for Mental Health and Substance Abuse Social Workers included in this section of the Guidelines are:

- 4.7.1 Credential Verifications for Applying Emergency Credentialing Standards for Mental Health and Substance Abuse Social Worker
- 4.7.2 Explanation of Credential Elements for Emergency Credentialing Levels for Mental Health and Substance Abuse Social Workers

*4.7.1 Credential Verifications for Applying Emergency Credentialing Standards for Mental Health and Substance Abuse Social Workers*

<b>MHSASW Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Verified
Active Clinical Practice	Verified

<b>MHSASW Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MHSASW Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>MHSASW Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

*4.7.2 Explanation of Credential Elements for Emergency Credentialing Levels for Mental Health and Substance Abuse Social Workers*

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<i>Unencumbered License</i> An active and unrestricted State issued license.	Possesses a current unencumbered license, as applicable, in Social Work.	Verified with applicable State agency.
<i>Degree</i> Academic title conferred by universities and colleges as an indication of the completion of a course of study.	Possesses an acceptable degree in Social Work from an accredited university or college.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Certification</i> A formal document that recognizes an individual has successfully completed the education, training, and experience needed to specialize in a certain area.	Possesses a document awarded by the Association of Social Work Boards evidencing successful completion of requirements for certification in Clinical Social Work or Alcohol, Tobacco or other Drugs Social Work.	Verified with the Association of Social Work Boards or by process acceptable to a JCAHO accredited healthcare organization.
<i>Active Clinical Practice</i> Active practice within the chosen profession.	The volunteer has an active clinical practice in Mental Health and Substance Abuse Social Work.	Attestation or documentation from the entity where the individual is practicing confirming active practice or a peer reference affirming the individual is actively practicing within the profession.

## 4.8 Emergency Credentialing Standards for Psychologists

*Psychologists* collect, interpret, and apply scientific data related to human behavior and mental processes. They may study the way people think, feel, or behave in order to understand, explain, or help them change their actions or manage stress. Psychologists specialize in a wide variety of areas such as clinical, social, counseling, industrial, school, educational, behavioral, experimental, rehabilitation/vocational, forensic, and neuro-psychology.<sup>8</sup>

Metrics include the verification of credential elements consisting of Degree, Unencumbered License, Certification, and Active Clinical Practice.

Supporting materials to describe emergency credentialing standards for psychologists included in this section of the Guidelines are:

- 4.8.1 Credential Verifications for Applying Credentialing Standards for Psychologists
- 4.8.2 Explanation of Credential Elements for Emergency Credentialing Levels for Psychologist

### 4.8.1 Credential Verifications for Applying Emergency Credentialing Standards for Psychologists

<b>Psychologist Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification	Verified
Active Clinical Practice	Verified

<b>Psychologist Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>Psychologist Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>Psychologist Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

#### 4.8.2 Explanation of Credential Elements for Emergency Credentialing Levels for Psychologists

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<p><i>Unencumbered License</i> An active license and with full and unrestricted privileges to provide services within the State's scope of practice laws as a psychologist. (Note: Scope of practice laws within a State may vary and limit practice to a particular specialization (e.g. School Psychologist).</p>	<p>Possesses a current unencumbered license, as applicable, in Psychology.</p>	<p>Primary source is recommended or JCAHO recognized organization that has performed primary source verification of the credential.</p>
<p><i>Degree</i> Academic title conferred by universities and colleges as an indication of the completion of a course of study.</p>	<p>Possess a degree in psychology that is sufficient to meet the licensing requirements to practice independently as a psychologist.</p>	<p>Primary source is recommended or JCAHO accredited organization that has performed primary source verification of the credential.</p>
<p><i>Certification</i> A formal document that recognizes that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.</p>	<p>A document awarded by the American Board of Professional Psychology evidencing successful completion of the requirements of one of its specialty boards.</p>	<p>Verified with The American Board of Professional Psychology or by a process acceptable to a JCAHO accredited healthcare organization.</p>
<p><i>Active Clinical Practice</i> Currently involved in the provision of direct patient care.</p>	<p>The volunteer has an active clinical practice.</p>	<p>Attestation or other documentation from the entity where the individual is practicing confirming active practice or a peer reference affirming the individual is actively practicing within the profession.</p>

#### 4.9 Emergency Credentialing Standards for Mental Health Counselors

*Mental health counselors* counsel with an emphasis on prevention, and work with individuals and groups to promote optimum mental health. Mental health counselors may help individuals deal with addictions and substance abuse; family, parenting, and marital problems; suicide; stress management; problems with self-esteem; and issues associated with aging and mental and emotional health. The definition, taken from the Standard Occupation Classification code, excludes "Social Workers" (21-1021 through 21-1029), "Psychiatrists" (29-1066), and "Psychologists" (19-3031 through 19-3039).

Metrics include the verification of credential elements consisting of Degree or Diploma, Unencumbered License, Certification, and Active Clinical Practice.

Supporting materials to describe emergency credentialing standards for mental health counselors included in this section of the Guidelines are:

- 4.9.1 Credential Verifications for Applying Emergency Credentialing Standards for Mental Health Counselors
- 4.9.2 Explanation of Credential Elements for Emergency Credentialing Levels for Mental Health Counselors

##### 4.9.1 *Credential Verifications for Applying Emergency Credentialing Standards for Mental Health Counselors*

<b>Mental Health Counselor Level 1</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Verified
Active Clinical Practice	Verified

<b>Mental Health Counselor Level 2</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Verified
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>Mental Health Counselor Level 3</b>	<b>Status</b>
Unencumbered License	Verified
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

<b>Mental Health Counselor Level 4</b>	<b>Status</b>
Unencumbered License	Indeterminate
Degree or Diploma	Indeterminate
Certification	Indeterminate
Active Clinical Practice	Indeterminate

#### 4.9.2 Explanation of Credential Elements for Emergency Credentialing Levels for Mental Health Counselors

<b>Credential Element</b>	<b>Evidence of Credential</b>	<b>Verification Mechanism</b>
<i>Unencumbered License</i> A State issued active license that has no restrictions.	Possesses current unencumbered license if license is required.	Primary source is recommended or JCAHO accredited organization that has performed primary source verification of the credential.
<i>Degree</i> This is not a recognized degree program and States may have different educational requirements for this behavioral health discipline. Therefore, each State must make a determination of degree and other training requirements.	Possesses the appropriate State required degree or training.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Certification</i> A formal document recognizing that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.	Possesses a document awarded by the National Board of Certified Counselors evidencing successful completion of the requirements of one of its specialty boards.	Verified with appropriate certifying body or by a process acceptable to a JCAHO accredited healthcare organization.
<i>Active Clinical Practice</i> Evidence that the volunteer is currently engaged in the practice of Mental Health Counseling within the scope of their license (if required by the State).	Volunteer is actively practicing as a Mental Health Counselor.	Attestation or other documentation from the entity where the volunteer is working or peer reference affirming the volunteer is actively working as a Mental Health Counselor.

#### **4.10 Notes on Establishing Emergency Credentialing Standards for Behavioral Health Professionals**

For purposed of the ESAR-VHP Program, Behavioral health consist of psychologists, medical and public health social workers, mental health and substance abuse social workers, marriage and family therapists and mental health counselors. Each of these occupations corresponds to a functional definition in the Standard Occupational Classification system.

There is State-by-State variability in licensing, certification, and educational requirements for the different kinds of behavioral health professionals. In addition, there are other practices such as equivalencies, called “grand-fathering” and other factors to consider when the ESAR-VHP emergency credentialing standards are applied to behavioral health professionals. These issues and others will be investigated and examined as the emergency credentialing standards are evaluated for each of the behavioral health professional classifications during the Guidelines testing period. Given the variation between States’ licensure and certification requirements for behavioral health professionals, certain types of licenses and certifications may not be recognized across State lines. As noted previously, legal advice should be sought to determine a health volunteer’s ability to practice in the receiving jurisdiction prior to permitting the professional’s deployment to practice in another jurisdiction.

If a behavioral health professional is granted clinical privileges, the emergency credentialing methodology should be consistent to that used for a physician when setting a credentialing level. Such distinctions, as they become apparent to the ESAR-VHP program, will be examined and addressed with appropriate modification to the Emergency Credentialing Standards section of the Guidelines. Prior to becoming a formal System requirement, all emergency credentialing standards introduced in the Guidelines will be evaluated during the Guidelines testing period.

#### **4.11 The Value of Developing a System to Provide the Highest Emergency Credentialing Levels**

When determining a health volunteer’s emergency credentialing level, the only *required* credential element in most cases is State licensure, which distinguishes between a Level 3 and Level 4 health volunteer. However, it is important to recognize that there is a direct correlation between the number of credential elements collected and verified and the utility of the System.

By choosing to collect a reduced set of credential elements, the System will be less able to distinguish the difference in potential capabilities offered by health volunteers. To illustrate the point, if licensure is the only credential collected, the System will only be able to assign an emergency credentialing Level 3 to health volunteers registered in the System. The limited differentiation places a greater burden on the requesting entity to gather and verify the critical credential information in order to make decisions on how to utilize a volunteer’s services. In general, a comprehensive set of credential elements collected and verified in an ESAR-VHP System will reduce the burden on the requesting entity to verify a health volunteer’s credentials during a disaster when there will be limited time or ability to perform such verifications on site.

By utilizing the ESAR-VHP System to more fully perform the information collection and verification processes, which are imperative to effectively using health volunteers in an

emergency, the possibility that of a volunteer's professional services being misappropriated or used ineffectively is reduced. Scarce resources of expertise and time are optimized.

Two fundamental considerations that will strongly influence the extent to which credential information is used to set the emergency credentialing level of health volunteers are legal and regulatory considerations and the likely role of the health volunteer.

#### *4.11.1 Legal and Regulatory Consideration*

Each State must determine if it has legal, regulatory, or other considerations that dictate how necessary credentialing elements may be collected and assembled on health volunteers. Furthermore, the accuracy of the information and the scope of practice authorized during an emergency may have significant ramifications regarding civil liability. The System must be developed with consideration for State legal requirements. State privacy laws may limit the acquisition methods for some types of information, as well as the use and disclosure of health volunteer information. For example, if State law only allows for the collection of information related to a health volunteer's licensure and professional degree, the extent to which the System may classify a health volunteer is Level 3. If this is all that can be determined about a health volunteer through the ESAR-VHP emergency credentialing standards process, the entity receiving the health volunteer must commit scarce time and resources to assessing the health volunteer's capabilities and validating credentials and qualifications during or after the triggering event.

Additionally, as previously discussed, there may be legal implications regarding the ability of the practitioners to practice across State lines. For a discussion of the legal and regulatory considerations of interstate practice, licensure, and credentialing, review section 3.2 of the Legal and Regulatory Issues Report.

#### *4.11.2 Likely Role of the Health Volunteer*

Based on System planning with members of the program advisory group, the State will gain an understanding of the strategic role health volunteers may play in the State's emergency response structure. This knowledge will help set the level of credential information needed. The following questions must be considered:

- Will it be crucial to be able to use System health volunteers, with proper levels of qualification, in a hospital setting within the State they are licensed, but at a location where they have no affiliation? If there is a significant need to satisfy this scenario, the State's credential information should be extensive. Without robust information on the health volunteer, hospitals may find limited value in the System capabilities. In an emergency, the burden would be placed on hospitals or other receiving entities to assess and authenticate the credentials that are not provided and validated by the System.
- Does the State's emphasis tend more toward the preparation of health volunteers to provide health services in non-clinical settings, rather than on preparing health volunteers to provide health services in a hospital setting? If so, the need for credentialing requirements will vary. The required comprehensiveness of information will be less than

that described in the preceding scenario based on the absence of some regulatory requirements which would apply in a hospital setting.

#### **4.12 Privileging of Health Volunteers**

It is important to note that clinical privileges are not granted by an ESAR-VHP System. Privileges are granted by a requesting entity, such as a hospital. The function of the System is to provide accurate and reliable credential and other information to facilitate the granting of privileges on site. The information maintained in the System does not make inference about the competency of the health volunteer to perform health services. The range of privileges given and the need for supervision remain under appropriate authority and control.

#### **4.13 State Approaches to Emergency Credentialing and the ESAR-VHP**

Examples of State approaches to credentialing have been prepared by Wisconsin, Connecticut, and Minnesota.

##### *4.13.1 Wisconsin's Approach to Credentialing and the ESAR-VHP System*



#### **Wisconsin's Approach to Credentialing with the ESAR-VHP System**

Wisconsin began developing its credential verification system in April 2004 by convening an expert panel consisting of volunteer representatives from the Wisconsin Hospital Bioterrorism Preparedness Program, Division of Public Health, and the Wisconsin Association of Medical Staff Services.

The goal of the panel was to create a "best case" scenario for a credential verification process for volunteer healthcare professionals. The panel felt that the credential verification system should initially concentrate on physicians, as physician credentialing was deemed to be the most complicated of the health professions. Other healthcare disciplines will be included as the program matures.

The panel established three (3) primary objectives of the ESAR-VHP System:

1. Define key credentialing elements to verify for health volunteers.
2. Develop a statewide database incorporating practitioners actively working in Wisconsin's accredited hospitals.
3. Promote available technology systems that are capable of immediately verifying a physician's credentials regardless if they are hospital affiliated or non-hospital based as well as verifying out-of-State practitioners that respond to a disaster or healthcare emergency in Wisconsin.

### *Credentialing Elements*

The panel determined that the baseline credentialing elements that should be collected and verified for all practitioners include:

- Professional License (all licenses held)
- CMS sanction information
- AMA Profile
- Board Certification and Specialty Training
- DEA License
- National Practitioner Databank query

Wisconsin's hospital-affiliated physicians have additional information collected in the registry including:

- Primary Contact information
- Staff category
- Primary specialty with corresponding clinical privileges
- Special qualifications
- Privilege limitation (if any)
- Professional Liability carrier and amount of coverage

The Wisconsin System does collect each of the credential elements necessary for determining emergency credentialing Levels 1, 2, 3, and 4 for each kind of health professional registered in the System.

### *Development of the ESAR-VHP System*

The overall premise of the current system is to encourage each hospital to rely on its existing credentialing processes. Wisconsin's model presumes the hospitals are accredited and in compliance with CMS or JCAHO requirements assuring similar standards of reliability. Wisconsin's ESAR-VHP System will leverage the credentialing information already being collected and maintained on practitioners by hospitals.

### *Technology Support*

The last objective was to provide a System to verify credentials for all health volunteers. Wisconsin decided to promote the utilization of a reliable commercial service to verify credential information. A service was selected that is commonly used by the States' hospitals and is considered economical and reliable. The use of the commercial service is voluntary at present, but it is highly recommended, because it is efficient and provides rapid verification of credential information for non-hospital affiliated physicians and responders from out-of-State.

### *Current Status*

The program has been presented twice by teleconference for public comment and feedback and it has been well received. WEAVR (Wisconsin Emergency Assistance Volunteer Registry) was implemented in Fall 2004 and is recruiting physicians with plans to include other healthcare disciplines in the System. The frequency of database updates is being refined. Linking the database to the proposed NIMS classification methodology is being evaluated as well.

Contributors are listed in Appendix 2.

### *4.13.2 Connecticut's Approach to Credentialing and the ESAR-VHP System*



#### **Connecticut's Approach to Credentialing with The ESAR-VHP System**

The Connecticut Statewide Emergency Credentialing System, which serves as the foundation for Connecticut's ESAR-VHP System, provides a mechanism for hospitals throughout

Connecticut to identify and expeditiously contact physicians and other staff to provide volunteer assistance in the case of a declared emergency. All 32 participating hospitals provide the Connecticut Credentialing System database with validated information about their active medical staff and affiliated professionals (PAs, APRNs, CNMs, and CNAs) that wish to volunteer in the event of a mass casualty event. In turn, a hospital is able to access credentialing information on health volunteers it may request from the statewide database in the event of a disaster. In a disaster, hospitals that utilize the statewide credentialing database are assured that registered volunteers have been "pre-qualified" by a peer hospital in Connecticut accredited by the JCAHO.

#### *Credentialing Elements*

The System requires the participating hospital to gather and verify extensive credentialing elements for all of the healthcare volunteers that the participating hospital includes in the System. The Connecticut System does collect each of the credentialing elements necessary to determine Levels 1, 2, 3, and 4 for each kind of health professional registered in the System. The complete listing of the elements and disciplines included is extensive. Participating hospitals are supplying information that they normally gather and maintain in the context of their normal practitioner and personnel oversight, with respect to medical staff and affiliated professionals.

In addition to the robust requirements to be entered into the system, consistent with the JCAHO standard on "Disaster Privileging" it is required for the requesting hospitals to repeat primary source verification of the volunteers it uses "as soon as the immediate situation is under control." This partial set of elements includes:

- Current licensure
- Relevant training
- Experience
- Current competence
- Verification of status and privileges with the primary hospital
- National Practitioner Data Bank inquiry required for all MD, DO, DPM, DDS, DMD, PA, APRN, CNM, Nurse Anesthetists

Participating hospitals are responsible for excluding from the database any volunteer for which the hospital has knowledge of any of the following: pending or current investigations, sanctions, encumbrances, by any health care facility (including the participating hospital itself), licensing board, DEA or State Narcotics agency, current illegal drug or alcohol abuse, privilege limitations that cause the individual to be unable to provide the basic privileges of their practice specialty.

The system encourages continuous monitoring conducted by participating hospitals to ensure accurate records of volunteer information. Participating hospitals are required to send (at a minimum) quarterly updates of their internal volunteer database to the statewide database in spreadsheet format. Additionally, participating hospitals are required to send an immediate update to the statewide database any time a volunteer is removed from the hospital database for the reasons identified above.

Volunteers who register for the statewide database agree to be contacted in emergencies and retain the right to refuse to provide services in any circumstance and for any reason. Connecticut's plan addresses volunteer deployment during four separate classifications of emergencies; two are locally declared and do not trigger State liability protections. Identification that volunteers are required to present upon arrival to a requesting hospital remains the prerogative and responsibility of the requesting hospital, however, the Connecticut plan recommends, at a minimum and consistent with the JCAHO standard, that its participating hospitals require a current, valid professional license (hard copy or by Internet) and *one* of the following:

- A valid photo ID issued by a State, federal or regulatory agency
- A current hospital photo identification card
- A Disaster Medical Assistance Team (DMAT) identification card
- Identification card confirming that the individual has been granted authority to render patient care in emergency circumstances, such as authority having been granted by a federal, State, or municipal entity
- Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

The requesting hospital or organization is responsible both for contacting the volunteers it requires in an emergency, and for ensuring the availability of malpractice insurance coverage for all volunteers it enlists. Any privileges granted to volunteers by the requesting hospital must comply with the hospital's medical staff bylaws and rules and regulations as well as any relevant internal staff policies and Joint Commission on Accreditation of Health Care

Organizations or equivalent standards. Hospitals or other organizations are only permitted to request volunteers when an official “state of emergency” is declared by the State or federal government or Chief Executive Officer or designee of the requesting hospital, and is accompanied by activation of that hospital’s “emergency management plan.” Volunteers cannot be requested from the Connecticut database in the event of a staffing shortage resulting from illness, vacation, recruitment issues, death, strike, walk-out, etc.

Contributors are listed in Appendix 2.

#### *4.13.3 Overview of Minnesota’s Approach to Credentialing and the ESAR-VHP System*



#### **Overview of Minnesota’s Approach to Credentialing and the ESAR-VHP System**

##### *Minnesota Responds! Health Professional Volunteer Registry*

The Office of Emergency Preparedness (OEP) within the Minnesota Department of Health operates and maintains Minnesota’s ESAR-VHP System. It was launched in October of 2004, with the initial objective of registering physicians, nurses, dentists, pharmacists, and behavioral health professionals.

##### *Credentialing for Deployment of Volunteer Health Professionals*

The credentialing process is still in its planning stages, but it has been decided that the process will be modeled on existing Joint Commission for the Accreditation of Healthcare Organization (JCAHO) standards. The plan is to use an approach of credentialing based on “tiers” to meet JCAHO standards for accredited hospitals and CMS requirements for Minnesota’s many critical-access hospitals.

Basic information about each volunteer will be entered into the Registry by the individual volunteer. Local public health agencies will track information regarding credentialing. It is the responsibility of the local public health agency (or a group of LPH agencies) to gather and verify credential information. Options are being considered for the best method to verify credential information, which will be done either directly with the health licensing boards, or with a credential verification organization.

##### *Access to Volunteer Information*

Once information is collected by the local public health agency, it will be entered into administrative fields through the MDH Workspace. Access to the information will be coordinated by OEP in the event that multiple counties or regions are involved. For local emergencies, direct access to the registry will be done by the local public health agency, which will assume responsibility for coordination and deployment volunteers.

*Next Steps*

1. Test the current methodology.
2. Include all health volunteers in the registry beyond the initial groups targeted.
3. Choose the credentialing methodology utilizing a tiered system and implement a credential verification process.

Contributors are listed in Appendix 2.

**4.14 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Determine alternative mechanisms to capture and verify information on credential elements used to set emergency credentialing standards for health volunteers.
- Investigate how national databases may be used to facilitate the process for establishing Emergency Credentialing Levels for health volunteers.
- Develop emergency credentialing standards for key medical and health professions.

## 5.0 Training and Situational Orientation

### 5.1 Overview of Training and Situational Orientation

This section describes the recommended items for how States should integrate training and situational orientation activities into an ESAR-VHP System.

*Recommended items in this section:*

- 5.2 Determine how training information will be integrated within the ESAR-VHP System.
- 5.3 Record training information within the ESAR-VHP System.
- 5.4 Review competency-based training overview.
- 5.5 Review existing State approaches to training and situational orientation.
- 5.6 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

The following terms are referenced in this section:

*Training* is defined as the formal activities and coursework taken by health volunteers to incrementally develop or enhance their ability to provide health services in a disaster scenario. Training must be specialized and acceptable to the State to prepare individuals to respond to a declared emergency. The training may be specific to different professional disciplines. Training, Disaster Training, and Disaster Preparedness Training are used interchangeably in the Guidelines.

*Situational Orientation* is a subset of training. It is training given to a health volunteer that corresponds to a specific emergency deployment. Situational orientation, also referred to as “just in time” training, is provided to health volunteers to prepare them for the specific situation in which they will provide assistance, and typically is recorded in the ESAR-VHP System after an emergency deployment has been completed.

*Competency* is a broad statement detailing a complex, but observable, set of behaviors including components of knowledge, skill, and attitude.

It is assumed that volunteers will already possess clinical knowledge and skills derived from their professional education and practice. The training described in this section addresses the additional knowledge and skill competencies that may be provided to a health volunteer in support of an emergency response; for example, knowledge about incident command or about methods to ensure personal safety.

Additionally, examples of approaches being taken by States to provide training and to record the training completed by health volunteers into an ESAR-VHP System are provided in Appendix 1.

### 5.2 Integrating Training Information into the ESAR-VHP System

While training is not required as part of an ESAR-VHP System and no specific training recommendations will be made within the ESAR-VHP Guidelines, information on training provided to health volunteers should be recorded in the ESAR-VHP System. Each State is

actively developing training programs and systems for health volunteers. In some cases, States have decided to require disaster preparedness training for participation in health volunteer programs.

While the ESAR-VHP System is not a training system, it is recommended that the ESAR-VHP System be utilized to collect a health volunteer's training information and potentially serve to monitor a health volunteer's ongoing training and disaster preparedness skill development. When assessing training programs, particularly those with an online component, States should consider how training will be delivered to volunteers, and how such information will be recorded by the ESAR-VHP System.

Any training requirement imposed by the States must be feasible, practical, affordable, and encourage the recruitment and retention of health volunteers. It may neither be possible to recruit busy professionals into an ESAR-VHP System if a volunteer must devote considerable time and effort to training, nor may specific training be necessary for the role that every volunteer will play in an emergency. Therefore, if a State is considering imposing a training requirement on health volunteers, the State should consider how critical the additional knowledge and skills developed through training will be for that individual to provide care in an emergency response situation.

Training programs should aid the volunteer in developing the knowledge, skill base, and competencies to function in any type of declared emergency. The training programs should also include mechanisms to assess the attainment of these competencies and a basic format for delivering the information to be recorded in an ESAR-VHP System.

### **5.3 Recording Training Information within the ESAR-VHP System**

The ESAR-VHP System does not provide requirements for States to record specific information on training, validate completed training prior to registration, or set the health volunteer's emergency credentialing level. Disaster preparedness training is not a required credential element with any of the health volunteer emergency credentialing standards, as described in the Emergency Credentialing Standards section.

While disaster training is not required under the emergency credentialing standards, States have the option of requiring disaster preparedness training for their ESAR-VHP volunteers. However, to ensure uniform emergency credentialing standards, disaster preparedness training must not be used to differentiate a health volunteer's emergency credentialing level classification from health volunteers included in an ESAR-VHP System. If a State establishes a mandatory requirement for disaster preparedness training of health volunteers registered in an ESAR-VHP System, then disaster preparedness training should be required for all emergency credentialing level classifications.

If a health volunteer completes State approved disaster preparedness training, it is recommended that that training information be recorded in the ESAR-VHP System. When assessing a request for volunteers from the ESAR-VHP System, it may be very useful to know a health volunteer's training information. The record of training should include whether the volunteer has met the

standards of the training, if defined by the State, and has maintained his/her knowledge base by participating in ongoing training, if deemed appropriate.

States should consider whether to verify training, as well as verify the certification of completed training. This may be done by independent verification by the State, personal attestation by the health volunteer, or automated verification through integration with an electronic learning management system. States could maintain a record of the volunteer's incremental competencies, based on the courses he/she has completed. This would assist in assignment of the volunteer to activities for which he/she is educationally prepared.

If the State does collect training information in the ESAR-VHP System, then that information should include:

**Course identification**

- The course title, code, and description which identifies the training course.

**Name of the institution, location, or provider of training course**

- The name of the entity providing the training.

**Completion date**

- When the training was completed.

**Expiration date**

- If and when training "expires" and must be renewed.

A State may also collect information on skills and competencies acquired with completed training. While minimal, the training information collected by the ESAR-VHP System allows for a basic record of the health volunteer's training and the ability to verify training information. Additional information on data definitions and formats are found in the Data Definitions section.

## **5.4 Overview of Competency-Based Training**

Competency-based preparedness education/training is a critical benchmark under the National Bioterrorism Hospital Preparedness Program for adult and pediatric pre-hospital, hospital, and outpatient health personnel responding to a terrorist incident. HRSA requires NBHPP awardees utilize a competency-based education model to bring more structure to the field of disaster preparedness education when using NBHPP funds.

Assessment of the volunteer's learning should be done by testing the knowledge gained in a course through a written examination. Ideally, training programs would further evaluate the trainee's skills through hands-on exercises, for example.

### **5.4.1 Competencies**

Competency is a broad statement detailing a complex, but observable, set of behaviors including components of knowledge, skill, and attitude. For example, a task force sponsored by the Office of Emergency Preparedness and the American College of Emergency Physicians developed a set

of competencies for emergency medical technicians, emergency physicians, and emergency nurses to care for casualties resulting from nuclear, biological, or chemical incidents. Competencies have not been created for all potential emergencies and all categories of health workers. For example, behavioral health workers do not have a set of competencies for treating individuals who are victims of a disaster or other mass casualty event. At this time, there is no national set of core competencies. While many sets of competencies have been developed, there has been less attention given to the creation of educational programs directly linking the competencies. It is important that a comprehensive set of competencies be created at a national level, and that they are used as the basis for educational programs developed by or made available to the States.

### **Bioterrorism Health Professional Competencies**

Health professional competencies addressing bioterrorism and other public health emergencies were created in 2001, prior to the events of September 11, 2001, and many currently are available. The report is summarized below.

*Developing Objectives, Content, and Competencies for the Training of Emergency Medical Technicians, Emergency Physicians, and Emergency Nurses to Care for Casualties Resulting From Nuclear, Biological or Chemical (NBC) Incidents: Final Report (April 23, 2001).*

The Department of Health and Human Services Office of Emergency Preparedness entered into a contract (282-98-0037) with the American College of Emergency Physicians to develop strategies to prepare Emergency Medical Personnel, specifically EMS providers, Emergency Physicians and Emergency Nurses to respond to a nuclear, biological or chemical incident. The task force members, that included representatives from each target audience and content experts, developed the performance objectives for the training. These performance objectives were extensively reviewed. Levels of proficiency were broken into three categories: awareness, performance, and planning. The objectives represent the knowledge and skills required for effective incident response. These objectives are precursors to the professionally specific competencies being developed. The report in its entirety can be obtained at <http://www.acep.org/library/pdf/NBCreport2.pdf>.

*Bioterrorism and Emergency Readiness: Competencies for All Public Health Workers (November, 2002)*

The Department of Health and Human Services Centers for Disease Control and Prevention let a cooperative agreement to the Association of Teachers of Preventive Medicine (TS 0740) and the Columbia University School of Nursing Center for Health Policy to define the competencies necessary for the public health workforce to address bioterrorism and other public health issues. The listing outlines nine core competencies for all public health personnel and specific additional competencies for the nine Public Health roles. This work serves as a model for the remaining health professions in establishing their discipline specific competencies and is available for downloading in its entirety at <http://cpmcnet.columbia.edu/dept/nursing/institute-centers/chphsr/btcomps.pdf>.

*Training Future Physicians About Weapons of Mass Destruction: Report of the Expert Panel on Bioterrorism Education for Medical Students (2003)*

The Department of Health and Human Services Centers for Disease Control and Prevention let a cooperative agreement to the Association of American Medical Colleges (U36/CCU 319276) to convene an expert panel to identify competencies addressing identification and response to Weapons of Mass Destruction (WMD) for all medical students. The report specifies not only the recommended educational content, but also suggests methods of instruction. The report in its entirety can be found at <http://www.aamc.org/newsroom/bioterrorism/bioterrorismrec.pdf>.

The competencies are broken up into the phases of medical education; Basic Sciences, occurring in the first two years, and Clinical Sciences, occurring in the remaining years of a four-year program.

*Educational Competencies for Registered Nurses Responding to Mass Casualty Incidents (August 2003)*

The International Nursing Coalition for Mass Casualty Education with support from the American Association of Colleges of Nursing developed and validated mass casualty nursing competencies. An extensive array of consortia members representing nursing education, national nursing associations, and federal offices collaborated on the production of the report. It is currently not published as it was approved in August 2003. The full listing can be found at <http://www.mc.vanderbilt.edu/nursing/coalitions/INCMCE/educomp.pdf>.

*Emergency Preparedness and Response for Hospital Workers (July 2003)*

The Center for Public Health Preparedness, Mailman School of Public Health, Columbia University with collaboration from the Greater New York Hospital Association and support from the Commonwealth Fund produced a set of Emergency Preparedness competencies for the hospital-based worker. Leaders from several New York hospitals gathered at four focus groups to develop a set of competencies for hospital workers of all types, from technical support to professional staff. The hospitals wanted a set of competencies that would extend beyond the professionally specific competencies and encompass skills observable in the workplace, and capable of being evaluated. They are in press and currently are not available.

*American Society for Testing and Materials (ASTM) International, ASTM Standard guide for Hospital Preparedness and Response, 2005.* Available online for purchase at <http://www.astm.org>.

*Occupational Safety and Health Administration (OSHA Best Practices for Hospital Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances, 2000.* Available online to download at OSHA's website <http://www.osha.gov>.

## **5.5 Overview of State Approaches to Training and Situational Orientation**

Examples of State and institutional approaches from Wisconsin, Texas, Connecticut, Georgia, International Nursing Coalition for Mass Casualty Education (INCMCE), and the University of Pittsburgh Medical Center (UPMC) Health System are provided in Appendix 1.

## **5.6 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Assist in the coordinated effort to identify a national, standardized set of competencies that should be achieved by health volunteers, and the identification of educational programs that prepare volunteers to meet the standardized competencies.
- Examine how training may be facilitated through the ESAR-VHP System during the initial Guidelines testing period, with emphasis on integration of learning management systems.

## 6.0 Health Volunteer Recruitment and Advocacy

### 6.1 Overview of Health Volunteer Recruitment and Advocacy

This section describes the recommended items to address recruitment and health volunteer advocacy issues, specifically, effective methods for attracting, recruiting, and retaining volunteer health professionals in a State-based ESAR-VHP System.

*Recommended items in this section:*

- 6.2 Review Steps to Building ESAR-VHP System Awareness and Recruiting New Health Volunteers.
- 6.3 Incorporate techniques to encourage registration of new health volunteers and retention of existing health volunteers in an ESAR-VHP System.
- 6.4 Provide for clear protections for health volunteers and provide authoritative answers to key questions from health volunteers.
- 6.5 Review existing State approaches on health volunteer recruitment and advocacy.
- 6.6 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

The following terms are referenced in this section:

*Recruitment* is the identification and subsequent registration of volunteer health professionals in a State-based ESAR-VHP registry. There is a distinction between “recruited” health volunteers, who are registered, coordinated health care professionals, and “spontaneous” health volunteers, who are unregistered, uncoordinated health care professionals, who may respond to an emergency or disaster situation.

*Health Volunteer Advocacy* denotes methods by which States can build awareness of the ESAR-VHP System and facilitate the registration and retention of volunteer health professionals in the ESAR-VHP System, including the identification and provision of effective incentives and necessary protective measures for health volunteers.

### 6.2 Building ESAR-VHP Awareness and Recruiting New Health Volunteers

Recruitment efforts will hinge, in part, on States’ success in reaching out to potential health volunteers by spreading awareness of the ESAR-VHP System. Currently, States with operational ESAR-VHP Systems have employed a number of diverse outreach strategies.

#### 6.2.1 Building Awareness

States may use a number of approaches, active and passive, to broaden awareness of an ESAR-VHP System on a general level, including: exhibits and/or presentations at professional conferences and/or health fairs, advertisements and/or articles in professional journals, professional association newsletters and electronic list-servs, and advertisements in the media (newspapers, radio, television).

### 6.2.2 *Partnering*

States may engage and seek the endorsement of associations and organizations that represent health care professionals, and enlist the assistance and support of these groups in promoting and building awareness for ESAR-VHP Systems. States, for example, may collaborate with professional licensing boards to combine recruitment efforts with licensure renewal. A useful approach may be to make prospective volunteers aware of a State's ESAR-VHP program as part of the licensure renewal process and to encourage ESAR-VHP registration at the time of licensure renewal. There are many partnering opportunities available to States as ESAR-VHP Systems are formalized. Potential partners may be invited to participate in planning for the overall ESAR-VHP System, as described in the Initial System Planning Activities section. As opportunities to partner with other organizations arise, States need to understand that planning the roles and responsibilities in the partnerships will be essential to its success.

### 6.2.3 *Direct Contact*

Through cooperation with hospitals, States may seek out hospital-based health care professionals directly. If the hospital staff is educated on the benefits and advantages of the ESAR-VHP System, the likelihood of support will improve. Alternatively, to reach those health care professionals not affiliated with hospitals, contact information may be obtained from licensure databases to enable direct mailings to those individuals.

Additionally, States may greatly facilitate health volunteer recruitment by working directly with other volunteer programs, such as the Medical Reserve Corps (MRC). Doing so could enable health volunteers to register concurrently for both volunteer programs, or, in some circumstances, could allow for integration of existing volunteer databases into the ESAR-VHP System.

The State ESAR-VHP Director/Administrator should contact the State MRC Coordinator (a list of State MRC Coordinators is available from the MRC Program Office at [MRCcontact@osophs.dhhs.gov](mailto:MRCcontact@osophs.dhhs.gov)) and any local MRC groups to generate support and interest among their volunteers to register on the ESAR-VHP System. Both the State ESAR-VHP and the MRC units will benefit from a collaborative effort. The MRCs will be able to utilize the ESAR-VHP program's emergency credentialing standards and emergency verification services. MRC members may then better mobilize in their own communities, State-wide, and perhaps even in interstate emergency response situations. Adding the MRC members to the new ESAR-VHP System will assist in populating the database with credentialed and qualified volunteers.

## 6.3 **Techniques to Encourage Registration and Retention of Existing Health Volunteers**

It is important that States facilitate registration of health volunteers and maintain health volunteers' long-term interest and involvement in the ESAR-VHP System. Below are some basic principles States may consider.

### *6.3.1 Easy Registration*

Registration on an ESAR-VHP System should be made convenient and easy. At minimum, the State should provide both electronic (preferably web-based) and paper-based means for health volunteers to formally register on an ESAR-VHP System.

### *6.3.2 Clear Scope of Participation*

Agreement on the potential scope of a health volunteer's participation in an emergency should be established with the volunteer well in advance of an emergency deployment. Information collected through the ESAR-VHP System on volunteer preferences should include:

- What distance(s) the health volunteer is willing to travel (miles) for deployment.
- How long the volunteer is willing to stay deployed.
- To what kind of incident or emergency is the volunteer willing to respond.

Volunteers must be informed that their answers are not binding and they are, at all times, free to decline calls to respond to an emergency for whatever reason.

### *6.3.3 Maintaining Health Volunteer Interest*

There are a number of successful techniques that a State may use to maintain a health volunteer's interest in and involvement with the ESAR-VHP System. Examples of techniques currently in use by States include:

- Maintaining regular contact with health volunteers through e-mails and newsletters.
- Collaborating with existing health volunteer programs, such as the Medical Reserve Corps, to offer relevant training, drills, and exercises to health volunteers.
- Partnering with organizations, such as the Medical Reserve Corps and American Red Cross, to provide awareness of ongoing community public health opportunities in which health volunteers may participate.
- Tracking health volunteers' service records and providing awards for sustained involvement and active service.
- Encouraging local businesses to recognize health volunteers by providing them with discounted goods and services.
- Providing CME/CEU credits for dedication of time and training obtained as a health volunteer.

## **6.4 Protecting the Interests of Health Volunteers**

Volunteers may potentially serve in dangerous situations with no demonstrable assurance that their personal interests are protected. Therefore, health care professionals may be apprehensive about including themselves in an ESAR-VHP System. Each State should be able to provide clear guidance and information on key questions to potential health volunteers prior to registering on ESAR-VHP. These questions include:

- What precautions are being taken by the State to protect health volunteers against disclosure of personal information contained in the ESAR-VHP System?
- What liability do health volunteers assume for actions taken while responding to an emergency?
- What protections are in place for health volunteers should a personal injury occur while responding to an emergency?
- What protections are in place for health volunteers should employment status be compromised as a result of temporary relocation for the purpose of responding to an emergency?

Answers to these questions will vary by State and may require additional input from legal and other experts within the jurisdiction. Without well developed, authoritative answers to these key questions, a State's ability to attract and recruit volunteers may be limited. States should therefore plan to provide assurances to potential health volunteers in each of the following areas:

#### *6.4.1 Confidentiality of Personal Information*

Health volunteer information collected by the ESAR-VHP System should be secure and confidential, particularly since it may be shared with other localities, regions, or States. States must ensure that the acquisition, use, disclosure, and storage of identifiable health-information are all consistent with federal and State health-information privacy laws. The Security and Privacy section addresses this issue in more detail.

#### *6.4.2 Liability Protection*

The State may protect health volunteers participating in the ESAR-VHP System from exposure to civil liability due to allegations of malpractice or other medical negligence (i.e. for actions performed as a health volunteer responding in the event of a declared emergency) by identifying and establishing proper legal protections. Legal protections from civil liability can arise through State laws and regulations such as Volunteer Protection Acts, Good Samaritan laws, and others. Information on those protections should be provided to health volunteers prior to registering with the ESAR-VHP System. For additional information, please see the Authorities and Emergency Operations section and section 3.3 of the Legal and Regulatory Issues Report.

#### *6.4.3 Personnel Protection*

Participation in an ESAR-VHP System may include an entitlement to workers' compensation in the event a health volunteer is harmed while responding to an emergency. Since workers' compensation eligibility is controlled by State law, States should consult legal counsel to assess workers' compensation coverage available to health volunteers during an emergency. States may consider the wider impact of a health volunteer incurring response-related harm, and may seek to develop mechanisms whereby such protections are expanded to health volunteers' families as well. For additional information about workers' compensation, please see section 3.4 of the Legal and Regulatory Issues Report.

#### 6.4.4 *Employment Protection*


The State should determine how to provide health volunteers employment protection in the event they are temporarily called away to provide health volunteer services for an emergency in another jurisdiction.

Because the ESAR-VHP System is a State-based initiative, there will be State-to-State variability as to the most appropriate means of addressing these issues. For additional discussion of the legal components of employment protection for health volunteers, refer to section 3.6.2 of the Legal and Regulatory Issues report. Legal counsel should be consulted to determine whether employment protections are available to health volunteers in the relevant jurisdiction.

### 6.5 **Existing State Approaches to Health Volunteer Recruitment and Advocacy**

Examples of State approaches to Health Volunteer Recruitment and Advocacy are provided for Connecticut, Wisconsin, and Texas.

#### 6.5.1 *Overview of Connecticut's Approach to Health Volunteer Recruitment and Advocacy*



CONNECTICUT DEPARTMENT OF  
PUBLIC HEALTH

Keeping Connecticut Healthy

#### ***Connecticut Health Volunteer Recruitment and Advocacy***

In November, 2002, the State of Connecticut Department of Public Health (CT DPH), in conjunction with the Yale New Haven Health System (YNHHS) and Hartford Hospital Centers of Excellence (CoE) for Bioterrorism Preparedness

and Response, the Connecticut Hospital Association and representatives of various clinical disciplines, established the statewide Emergency Credentialing System (ECS) Committee to address challenges associated with the goal of increasing personnel surge capacity, according to the direction of the HRSA NBHPP grant. Engaging the right organizations during the planning process ensured acceptance and support of the program by Connecticut's acute care hospital community and the healthcare professionals that staff those facilities. Physicians and mid-level practitioners (e.g. physician assistants, certified nurse midwives, certified nurse anesthetists) were selected as the pilot group to leverage the existing systems within healthcare institutions that verify and monitor physician licensing and credentialing.

A Participating Hospital Policy, Protocol, and Agreement was developed and approved by the statewide ECS Committee and the Connecticut Association of Medical Staff Services. These policies clearly stipulate the responsibilities of the participating institution including recruiting volunteers from their medical staff, validating volunteer credentials and submitting volunteer information (name, discipline, contact information, licensure, etc.) to the central ECS repository maintained by the YNHHS CoE. Currently, 31 of Connecticut's 32 hospitals are participating in the program, and have recruited more than 1,700 physician and mid-level practitioner volunteers. Leveraging information residing in the licensure databases at CT DPH and the Department of Consumer Protection (pharmacists), recruitment brochures were sent to more than 100,000 licensed healthcare professionals in Connecticut, expanding the program to include nursing, behavioral health, respiratory therapy, diagnostic imaging, laboratory medicine, and pharmacy professionals. These licensure databases will be used on an ongoing

basis to identify newly licensed individuals, as well as those who have allowed licenses to lapse or whose licenses have not been renewed due to disciplinary action. The program has been widely promoted by the State's healthcare professional societies through their journals, newsletters, and annual meetings. The committee continues to meet regularly to consider further program modifications and expansion to other healthcare professions and support services.

Early in the process, the CT ECS Committee identified the issues of liability insurance and Worker's Compensation as being significant obstacles to engaging healthcare practitioner cooperation as volunteers. Through the CT DPH and the Office of Policy and Management, State legislation was drafted and approved that (1) incorporated these volunteer healthcare practitioners into the Connecticut Medical Reserve Corps (MRC) and (2) provided liability insurance and Worker's Compensation coverage for MRC volunteers during training for and participation in a Governor-declared disaster event. This type of legislation is a critical component of engaging volunteers, ensuring that they and their families are adequately protected financially from litigation and injury as a result of their efforts as volunteers.

Contributors are listed in Appendix 2.

#### *6.5.2 Overview of Wisconsin's Approach to Health Volunteer Recruitment and Advocacy*



##### ***Wisconsin Health Volunteer Recruitment and Advocacy***

The Wisconsin Emergency Assistance Volunteer Registry (WEAVR), developed and managed by the Wisconsin Department of Health and Family Services/Division of Public Health (DPH), was launched in November 2003.

Due to concerns about the security and confidentiality of health volunteers' personal information it contains, WEAVR is housed within the Wisconsin Health Alert Network (HAN), where the State's Command Caller system originates. The registry is a secure password protected database system that allows health professionals the ability to indicate their willingness to volunteer in an emergency or disaster. The system is also designed for rapid query by DPH staff and includes the ability to contact volunteers as needed. WEAVR is listed as an organization on the HAN so that retired and other non-practicing licensed professionals not currently associated with another health-related organization are able to register. Initially, retirees and others unable to list an affiliation with a health related organization were not granted admission to the HAN due to concerns about the maintenance of HAN security. Discussion with HAN developers resulted in the WEAVR organization solution and enhancements were incorporated. Other enhancements may be forthcoming based upon ESAR-VHP guidelines from HRSA.

Volunteers provide contact information during the registration process and complete data fields that indicate the maximum distance they are willing to travel for an emergency, number of consecutive days they are willing to provide aid following an emergency, and information concerning their wishes to receive preparedness training from local partners. Data fields to indicate health professional status include degree, license, certification, and specialized skills.

In addition, affiliation with other volunteer or military organizations is recorded. Volunteers, if and when called upon, always have the option to decline service.

A plan for recruitment was developed after discussion with partner organizations such as the Wisconsin Medical Society and the Department of Regulation and Licensing. Strategies include informational inserts with license renewal notices of select health professions, presentations at health related association conferences, direct mail, and articles in professional journals and newsletters. Cooperation with the Pharmacy Society of Wisconsin (PSW), namely the provision of information by DPH for inclusion in PSW conferences and journal articles, has aided in recruitment of pharmacists and pharmacy technicians. DPH is also collaborating with Wisconsin human service program leaders to coordinate the recruitment of behavioral health professionals to WEAVR. As of January 2005, nearly 850 health professional volunteers are registered in the system.

WEAVR may accessed at <http://dhfs.wisconsin.gov/preparedness/WEAVR/>

Contributors are listed in Appendix 2.

### 6.5.3 Overview of Texas' Approach to Health Volunteer Recruitment and Advocacy



#### ***Texas' Health Volunteer Recruitment and Advocacy***

The Texas ESAR-VHP System faces unique challenges due to the size of the State, including the impracticality of a single centralized volunteer registry.

Texas is utilizing existing resources at local, State, interstate, national, and international levels. Texas has two existing medical volunteer programs that are the basis for the ESAR-VHP System: the Texas Ready Nurse Program, a volunteer group that serves as a Statewide registry, and the Texas Medical Rangers, a multi-disciplinary and academic-based group that is a component of the Texas National Guard. The volunteer program of about 150 members trains physicians and nurses and can be activated during a major disaster to respond to or supplement hospital needs. New partnerships have been established with several State groups in Texas to create a volunteer system. These efforts have led to the development of identification cards for health care professionals to practice in different hospitals during an emergency.

Questions related to workers' compensation and other liability concerns still need to be addressed. Legislation recently passed in Texas protecting health care providers during a recognized disaster covers individuals, but not hospitals or other facilities.

Contributors are listed in Appendix 2.

## **6.6 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Work with national volunteer organizations, including the Medical Reserve Corps and American Red Cross, to assess strategies at the State and national level.
- Develop a fact sheet and awareness kit with materials to assist States with developing effective ESAR-VHP community awareness programs.

## **7.0 Funding and Cost**

### **7.1 Overview of Funding and Cost**

This section of the Guidelines describes the recommended items for States to follow when estimating the costs involved in developing and maintaining an ESAR-VHP System.

*Recommended items in this section:*

- 7.2 Review information on supplemental funding and System sustainability.
- 7.3 Determine the areas of System costs related to:
  - 7.3.1 System design.
  - 7.3.2 Collecting health volunteer registration.
  - 7.3.3 Collecting and credentialing information.
  - 7.3.4 Emergency use and verification.
  - 7.3.5 Staffing for Systems maintenance.
- 7.4 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

### **7.2 Supplemental Funding and System Sustainability**

The development of a State ESAR-VHP is one of the requirements under the NBHPP cooperative agreements. The HRSA ESAR-VHP supplemental grant funds of \$200,000 per NBHPP awardee provided in either 2004 or 2005 are intended to further assist States in the initial development and operation of an ESAR-VHP System. In addition, HRSA will provide each awardee with technical assistance during the phased implementation of ESAR-VHP program.

During the testing period (January through June of 2005), emphasis will be placed on identifying and sharing effective strategies to minimize costs incurred by States during the development of the ESAR-VHP System. Recommended operational approaches and technical principles found throughout these Guidelines, along with the technical assistance provided to States during the ESAR-VHP program implementation period, are designed to help States leverage existing effective practices and minimize duplication of efforts. In addition, the program team will assemble and share with States information and knowledge on how to enhance systems that result in improved System development, sustainability, and best use of available resources resulting in overall lower ESAR-VHP System development costs.

### **7.3 Determining Key Areas for System Cost**

The most significant out-of-pocket costs for the development of the ESAR-VHP Systems generally fall into the following categories:

1. System design
2. Collecting health volunteer registrations
3. Collecting credentialing information
4. Emergency verification and use
5. Staffing for Systems maintenance

In some cases, States may leverage existing State systems that require some modification, but avoid the cost of developing programs from the “ground up.” States can apply this approach to system design, system operations and maintenance, training, and recruitment activities among others.

### *7.3.1 Costs for Systems Design*

Implementing a System design includes the need for hardware, software, and human support costs incurred to perform the functions required by the ESAR-VHP System. Depending upon the System design, overall costs may vary greatly. The key to minimizing costs is to determine the System design needs through thoughtful planning and assessing whether existing databases and technology platforms may be assembled to perform the required System functions.

In many cases, States have existing data systems and State-owned technology platforms that are ideal for beginning the ESAR-VHP System development activities. There may be existing systems that can be modified to either meet functional requirements of the ESAR-VHP System or provide complementary enhancements that benefit from the ESAR-VHP System. A State licensing database is a common example of an existing database system that may be modified or integrated to meet the functional requirements of the ESAR-VHP System.

### *7.3.2 Costs for Collecting Health Volunteer Registrations*

One measurement of success for the ESAR-VHP System effort is the number of health volunteers who are registered, assigned an emergency credentialing level, and may be called upon to respond in a disaster. States may use a wide-range of approaches to build health volunteer participation, but must consider the costs of each. Data acquisition costs, specifically building mechanisms to integrate existing volunteer programs into an ESAR-VHP System to build up the population of registered health volunteers, will vary greatly from State-to-State. Costs will be incurred to perform activities such as integrating databases of existing State volunteer programs or collecting new health volunteer registrations through electronic applications, paper applications, or developing new mechanisms for health volunteers to register within an ESAR-VHP System. There will also be additional marketing costs to broaden the awareness of each State’s ESAR-VHP System. During the Guidelines testing period, emphasis will be placed on identifying successful cost effective campaigns to recruit and facilitate awareness of the ESAR-VHP System.

### *7.3.3 Costs for Collecting Credentialing Information*

Quality information, particularly credentialing information, is at the heart of the ESAR-VHP System. There may be a significant cost for having access to credentialing information to fulfill the requirement of applying emergency credentialing standards. To justify the costs of assembling a robust set of credential information for health volunteers registered in a System, hospitals, public health authorities, and other System information users must perceive the value of the credential information that is collected and maintained to justify the cost. The benefit of providing information, whether State-owned (licensure database) and/or third party owned (such as American Board of Medical Specialties), must be worth the cost. As discussed in the Emergency Credentialing Standards section, a key determinate in the level of information needed for the System depends on the how the System will be used.

System costs will vary significantly depending upon whether the State wishes to collect third-party primary source data or utilize hospitals as Credentialing Verification Organizations for credential information verification. In many cases, there will be a high degree of similarity between the information hospitals collect for medical and professional staff functions and what may be required by the ESAR-VHP System to meet the needs of the very same hospital users.

States may seek to leverage existing systems that cooperatively aggregate information resources already in place within hospitals. A hospital-based system, where hospitals serve as CVOs, is only feasible with active full cooperation and participation of the State's hospitals and public health authorities. Further, a System utilizing hospitals as CVOs may need the support of specific legislation addressing System creation and related liability and health volunteer issues. While the hospital-based model may not be feasible for many States, where possible, such a model may result in significant cost savings for data acquisition and credentialing information.

#### *7.3.4 Costs for Emergency Verification and Use*

A cost assessment should account for the development and implementation mechanisms necessary to produce an ESAR-VHP System capable of providing emergency verifications of System information. A State may decide to integrate a physical identification card to identify a health volunteer on-site during an emergency. A number of States will utilize their DMV system to process and create photo ID cards. The benefits of using a DMV include an existing infrastructure to support card issuance, accessibility for health volunteers to receive ID cards throughout the State, and reasonable costs for printing and photographing. The potential limitation of using DMV's existing systems is that there may be minimal ability to customize the ID card provided by the DMV to display the desired ESAR-VHP System information. In addition, there may be technical or other restrictions that make using DMV capabilities to issue ID cards impractical. It is important for States to consult with the State DMV during ESAR-VHP System development to determine if the System can utilize DMV practices and processes.

Once an ID card is in place, it is possible to affix a sticker to the back of the card certifying the health volunteer's emergency credentialing level and may additionally include specific information on training, licensure, and special certifications. While this method is low cost, it does have limitations. Once an individual is issued a sticker, it is difficult to get it back in the event the user is no longer part of the ESAR-VHP program or changes status within the System, such as with emergency credentialing level classification. Encoding information on the ID card, by using a bar code or a magnetic strip, may also contain specific information on the health volunteer's capabilities. However this method will only be as current as when the information was encoded on the ID card. It is preferred for ESAR-VHP Systems to have the capability to access the most currently available information.

To ensure privacy and security, some States have indicated they are considering using an advanced and more expensive type of identification system, such as smart cards or programmable RFID cards. Smart cards, for example, permit easy updating of the health volunteer's complete record by storing the information on a computer chip located on the ID card itself. This information can be updated every time an individual inserts it into a reader connected to the ESAR-VHP System or updated on-site upon deployment. Using smart cards incurs costs not only for the individual cards, but also for infrastructure and support with such

items as card readers and user training. Regardless of the method, the consensus view of members of the NBHPP community is that health volunteers must carry an ID card at all times.

The cost to ensure the continuity of System operations in an emergency situation must also be factored into each State's cost assessment. States must ensure that the System remains operational during an emergency. It may be costly to maintain a System in a highly secure manner and tightly controlled environment, consisting of strong logical and physical System protections, but it is imperative. A thorough back-up plan for the ESAR-VHP System is essential. As described in the System Operations and Maintenance section, in the event of a disaster, it is possible that network systems will not be accessible electronically and it may be necessary to revert to paper or stand-alone digital back-up systems. The costs of implementing a back-up plan to cover items such as a redundant System and servers, frequent System back-ups, and maintaining alternate mechanisms to access ESAR-VHP System information can be significant.

#### *7.3.5 Costs for Staffing for ESAR-VHP System Maintenance*

Trained personnel are required to maintain and operate the System once it is developed. The System administration may be handled by internal staff or delegated to private organizations. Considerations must also be made for the availability of the System and the potential need for 24/7 staffing to respond in the event of an emergency.

### **7.4 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Assemble cost-effective practices nationally on how States are integrating existing technologies that support public health or emergency functions with the ESAR-VHP Systems.

## 8.0 Security and Privacy

### 8.1 Overview of Security and Privacy

This section describes recommended items for addressing security and privacy issues inherent in the development and operation of an ESAR-VHP System.

*Recommended items in this section:*

- 8.2 Understand the security and privacy issues inherent in an ESAR-VHP System.
- 8.3 Understand federal, State, and local privacy laws.
- 8.4 Take necessary precautions to protect health volunteer information by implementing security procedures for System users and operations, including:
  - 8.4.1 Security procedures for non-administrative System users.
  - 8.4.2 Security procedures for administrative System users.
  - 8.4.3 System operation security procedures.
- 8.5 Review initial minimum System security standards template.
- 8.6 Review issues with portability and communication of health volunteer information.
- 8.7 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

The following terms are referenced in this section:

*Security* refers to the technological and managerial means by which States protect the availability, confidentiality, and integrity of an ESAR-VHP System and the information it contains.

*Privacy* refers to the rights of health volunteers to control the uses and disclosures of their identifiable information acquired within an ESAR-VHP System.

### 8.2 Understanding the Security and Privacy Issues Inherent in an ESAR-VHP System

The creation, maintenance, and operation of a State-based ESAR-VHP System introduces a number of concerns with respect to the security and privacy of a health volunteer's information. States must take the necessary precautions to maintain the privacy of identifiable information privacy as required by law, while mitigating the inherent risks of operating a complex, networked System. Therefore, in developing and operating an ESAR-VHP System, a State must consider the following key issues:

- Sensitivity of health volunteer information
- Privacy controls, policies, and laws
- Information and physical System security standards
- Portability and communication of health volunteer information

The Guidelines will identify minimum conditions that must be in place to secure an ESAR-VHP System and the information it contains.

### **8.3 Understanding State and Local Privacy Laws**

By indicating the willingness to respond to an emergency, and registering within a State-based ESAR-VHP System, a health volunteer does *not* surrender his or her right to privacy, but rather gives permission for personal information to be used in limited, specific ways the event of an emergency. All aspects of how the information contained in an ESAR-VHP System is collected, assembled, accessed, and utilized must be consistent with applicable federal, State and local privacy laws and be clearly explained to the health volunteer prior to ESAR-VHP registration.

As described further in the Authorities and Emergency Operations section, each State ESAR-VHP System must comply with all applicable federal, State, and local privacy laws. Existing State and local privacy laws may potentially affect the acquisition, use, storage, and disclosure of information, as well as the information collection process and the type of information that may be collected concerning a health volunteer. It is recommended that States include legal and health-information privacy experts during the planning and implementation of an ESAR-VHP System to assess the relevance and applicability of these privacy laws.

In most cases, however, State and local privacy laws allow for the acquisition, use, and disclosure of this data provided the volunteer provides written, informed consent. Thus, so long as individual volunteers specifically authorize the acquisition, sharing, and disclosure of identifiable personal data for the purposes of implementing an ESAR-VHP System, most privacy issues can be alleviated. For more information on legal issues related to information privacy, including helpful cites to resources examining the HIPAA Privacy Rule, please refer to section 3.6.1 of the Legal and Regulatory Issues Report.

### **8.4 Taking Necessary Precautions to Protect Health Volunteer Information**

An ESAR-VHP System will contain sensitive information pertaining to health volunteers. Sensitive information may include:

- Personal contact information (e.g. address, phone numbers)
- Social Security Number
- Professional information (e.g. license status, disciplinary actions)

While some of this information, such as a health volunteer's professional license number or contact information, may be publicly available through other sources, extreme care must be taken to protect the confidentiality of all information once stored in an ESAR-VHP System.

In many States, the ability to collect Social Security Numbers is highly restricted. Therefore, the use of a health volunteer's Social Security Number as a unique identifier may be problematic and is discouraged. Instead, States should consider generating a unique identifier for each health volunteer registered in an ESAR-VHP System, as described in the Data Definitions section.

Because an ESAR-VHP System will collect and aggregate health volunteers' personal and professional information, States may face a high level of scrutiny from stakeholders regarding potential misuse of System information. States must protect against compromising the privacy of health volunteer information by allowing access to the ESAR-VHP System under clearly

defined conditions to authorized individuals only. Careful consideration should be given to who has access to the ESAR-VHP database and how much information authorized personnel may access. Any breach of a health volunteer's privacy may undermine the public's trust of the entire System.

It is essential to the proper operation of an ESAR-VHP System for the State to develop and implement means for ensuring the security of the System and the information the System contains. The recommended minimum procedures are:

- Security Procedures for Non-administrative System Users
- Security Procedures for Administrative System Users
- System Operation Security Procedures

#### *8.4.1 Security Procedures for Non-Administrative System Users*

Non-administrative users are individuals, such as health volunteers, with access to narrowly defined ESAR-VHP System information only, usually their own personal information. Since most non-administrative access to an ESAR-VHP System will occur remotely, System access must be protected by an authentication scheme.

#### *8.4.2 Security Procedures for Administrative System Users*

Administrative users are individuals with some level of direct access to or control of ESAR-VHP System information and command of System functions, which include registration, applying emergency credentialing standards, and emergency verification. Administrative accounts should only be accessed via pre-defined secure System areas. Each State should draft a formal hierarchy of administrative privileges for administrative users of an ESAR-VHP System.

#### *8.4.3 System Operation Security Procedures*

ESAR-VHP Systems must offer a level of security commensurate with the sensitivity of the data contained in the database. Maintaining the most current software versions through frequent updating protects the System against intrusion and may allow for increased System functionality. In addition to software updates, the System Administrator must be able to control electronic access to the System.

When data is transferred electronically between a System and other databases, the data should be encrypted to reduce the risk of its interception by unauthorized parties. To provide additional security, network segments on which an ESAR-VHP System resides can also be equipped with intrusion monitoring systems, of which a wide range are available. Such systems provide additional safeguards against malicious cyber-activity.

Yet, even the most digitally secure systems are vulnerable to intrusion if proper physical security precautions are not taken. ESAR-VHP Systems should reside in physically secure environments allowing for limited access by authorized individuals. Additional physical security considerations include hosting the System in a well-secured location with environmental (e.g. flooding and fire) protection systems, intrusion alarms, and monitoring by trained and competent personnel.

Other recommended practices for System operation include:

- Identifying and documenting business partners and shared security responsibilities for System use.
- Documenting and regularly updating the computing environment(s) on which an ESAR-VHP System is hosted and maintained (e.g. architecture, network diagrams, infrastructure, critical systems, and applications).
- Conducting periodic internal and independent external security assessments (of both the organization itself and partners that provide vital services).
- Identifying specific individuals to serve as security managers for an ESAR-VHP System at the State level.
- Establishing a business continuity/disaster recovery plan.

### 8.5 Establishing Minimum Security Standards for ESAR-VHP Systems

Based on the importance of maintaining a secure ESAR-VHP System, formal security standards will be developed during the testing period. The existing practices and recommendations provided by the State of Wisconsin will serve as the initial template for security standards for all ESAR-VHP Systems.



#### **Initial Template for Minimum System Security Standards Provided by the State of Wisconsin**

To maintain the security of the registration and credentialing systems, it is recommended that all States adopt the following minimum standards for personal, administrative, and technical security practices:

##### *General Security Standards*

ESAR-VHP Systems are to be run on dedicated computer(s).

All data must be transmitted via SSL or SSH protocols.

Passwords are to be at least six (6) characters in length and contain a mix of upper and lower case alphanumeric characters. They are to be changed every 60 days and kept confidential.

On-site back-ups are to be completed nightly with a copy moved off-site every week. Back-up files must be encrypted before storage. All back-ups are to be stored in a secure location.

1. Internal security assessments are to be conducted quarterly and external (independent) security assessments are to be conducted at system launch and again each year.
2. All users are to have their own User ID with access rights restricted to their job function.

##### *Hardware/Software Security Standards*

1. Network hardware security is to be ensured by:
  - a. Data center access being restricted using locked door, logged key-card, or other secure access method.
  - b. Installing environmental protections (fire, water).

- c. Providing back-up services and utilities (power, systems, and data).
- d. Developing, implementing, and continually testing rapid recovery procedures.
- e. Perform periodic data and application back-up (both on-site and off-site).
2. The computer operating system is to be kept up-to-date to the extent possible with necessary patches applied regularly.
3. Anti-virus software is to be installed and automatic updates should be set to run no less than daily. A full system scan is to be performed no less than weekly.
4. Operating systems and application software are to be patched for security purposes as frequently as necessary. Functionality updates should be applied as desired.
5. External vulnerability testing is to be performed during System launch and again each quarter.
6. Hardware and/or software is to be installed to provide:
  - a. Intrusion detection
  - b. Intrusion prevention
  - c. Patch management
  - d. Firewalling
  - e. Event monitoring
  - f. Logging
  - g. Encryption
  - h. Virus protection

#### *Administrative Security Standards*

The following are practices that organizations holding registration and credentialing information should take to ensure that its systems and data are secure:

1. There are to be policies and procedures, to be determined at the State or organizational level, governing the activities of System users.
2. The organization must identify security responsibilities and staff to meet them (e.g. security manager).
3. Users and developers must have security awareness training.
4. All information on the System is to be categorized (e.g. public or private) and protected in a manner consistent with its categorization:
  - a. Procedural: for each category of information there are to be established protocols on who can access the information and at what times.
  - b. Physical: (see Hardware Standards) for each category of information there is to be the appropriate level of physical security.
5. The computing environment (e.g. architecture, network diagrams, infrastructure, critical systems, and applications) is to be documented and regularly updated.
6. Procedures are to be implemented for patch control, software development, and business continuity/disaster recovery, all of which must be tested on a semi-annual basis.

Contributors are listed in Appendix 2.

## **8.6 Facilitating Portability and Communication of Health Volunteer Information**

Portability, or the ability to share health volunteer information between regions and States in an emergency to enable the sharing of health volunteers, is a fundamental objective of the ESAR-VHP program. States must therefore consider the issues raised by the prospect of not only obtaining and storing information within an ESAR-VHP System, but also of sharing it.

Health volunteers must be made aware that their personal information may be shared with other States during a multi-State declared emergency. To facilitate System portability, certain mechanisms must be in place to authorize communication among State-based ESAR-VHP Systems. It is important to note that health volunteers should be able to define their willingness to volunteer both inside and outside of the State in which they are registered, as indicated in the Data Definitions section under Health Volunteer Authorizations and Acknowledgements.

## **8.7 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Establish a formal checklist of minimum security standards for System Administrators on recommended security procedures based on initial recommendations provided by the State of Wisconsin, based on the initial template introduced in Section 8.5.

## 9.0 Authorities and Emergency Operations

### 9.1 Overview of Authorities and Emergency Operations

This section describes recommended items for States to examine to develop an understanding of the formal legal and other powers that underlie the creation, maintenance, and use of an ESAR-VHP System, with emphasis on performing essential ESAR-VHP System functions and emergency operations.

*Required items in this section:*

- 9.2 Understand the unique legal and regulatory structures surrounding the development an ESAR-VHP System.
- 9.3 Understand the legal issues underlying an ESAR-VHP System by assessing the State's existing statutory or administrative authority related to:
  - 9.3.1 Emergency declarations.
  - 9.3.2 Civil liability issues.
  - 9.3.3 Workers' compensation.
  - 9.3.4 Licensure, credentialing, and privileging.
  - 9.3.5 Criminal liability issues.
  - 9.3.6 Use of ESAR-VHP System information.
  - 9.3.7 Dispatching volunteers.
- 9.4 Delegate power to local authorities or other entities to administer primary ESAR-VHP functions once formal State authority is set to establish the ESAR-VHP System, including:
  - 9.4.1 Registration.
  - 9.4.2 Applying Emergency Credentialing Standards.
  - 9.4.3 Emergency verification.
- 9.5 Determine appropriate protocols for ESAR-VHP System use.

*Recommended items in this section:*

- 9.6 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

The following terms and definitions are used frequently in this section.

*Authorities* are the constitutional, statutory, regulatory, or other legal powers of State and local governments to control functions of the State's ESAR-VHP Systems.

*Emergency Declaration* refers to the State (or local) government's capacity to declare a general emergency or public health emergency, or state of disaster. Nearly every State has developed a legal structure for declaring an emergency or state of disaster, and many States have legal procedures for declaring public health emergencies. See the Legal and Regulatory Issues Report, Section 3.1, for more information.

A detailed examination of legal and regulatory issues related to the planning, administration, and use of an ESAR-VHP is available in the Legal and Regulatory Issues Report. Some cross-references to the Legal and Regulatory Issues Report are provided within this section to facilitate potential, additional review.

## 9.2 Understanding Unique Legal and Regulatory Structures Surrounding ESAR-VHP Systems

When establishing an ESAR-VHP System each State must consider the unique legal and organizational structure under which the System will be established. In all cases, the State, rather than local jurisdictions, should be the central authority that establishes, administers, and activates the System. A State-based, centralized approach is desirable to ensure legal authorities, procedures, and terminologies are clear and consistent throughout local jurisdictions in each State.

Legal consistency throughout the State is vital for an effective ESAR-VHP System. Participating health volunteers and health care organizations must be aware of and be able to understand the applicable legal authorities (e.g., ability to declare an emergency and activate the System), legal requirements (e.g., duty to protect the privacy of information in the System), and legal protections (e.g., availability of immunity from civil liability for health volunteers participating in an ESAR-VHP System responding in an emergency). Once the ESAR-VHP System has been established, the State may appropriately delegate necessary authority to perform the essential functions of the ESAR-VHP System, as described later in this section.

A State may exercise multiple options to establish and administer an ESAR-VHP System, including setting up the System within its existing statutory and regulatory framework. The State may choose, for example, to establish the System within its existing department of health, provided there is adequate legal authority to do so under current laws. Alternatively, a State may create a new statutory or regulatory framework for the ESAR-VHP System, or an authorized State government official (e.g. Governor or health commissioner) may establish the System through executive orders or other legal routes.

Depending on the chosen legal route for establishing an ESAR-VHP System, States may recognize that there are legal boundaries, or limits, on the design, use, and effectiveness of the System. When establishing the System, it is imperative to understand the State's existent statutory or administrative authority related to:

- *Emergency declarations:* declaring a general state of emergency, a public health emergency, or a disaster.
- *Civil liability issues:* applying civil liability or immunity/indemnification from civil liability to health volunteers, organizational entities accepting or providing health volunteers, and entities administering the ESAR-VHP System.
- *Workers' compensation:* providing workers' compensation protections to health volunteers who are injured during an emergency response.
- *Licensing, credentialing, and privileging requirements:* permitting health volunteers from other jurisdictions to assist in an emergency in light of professional licensure, credentialing, and privileging requirements.
- *Criminal liability issues:* applying criminal liability provisions to the acts of health volunteers and organizational entities accepting or providing health volunteers.
- *Use of ESAR-VHP System information:* collecting, maintaining, and sharing personal information on citizens within an ESAR-VHP System.
- *Dispatching health volunteers:* dispatching health volunteers in an emergency.

## **9.3 Assessing the Existing Legal Issues of the System**

### **9.3.1 *Emergency Declarations***

Emergency declaration laws are important to the creation and utilization of an ESAR-VHP System because these laws authorize State and local governments to prepare for and respond to emergencies. Likewise, the legal powers and protections that exist during a declared emergency may facilitate the operation and success of an ESAR-VHP System. Emergency declarations authorized under State law, typically confer upon the governor (or another designated entity, such as a health commissioner or emergency management officer) additional powers and duties to respond to the emergency.

State emergency laws are typically structured in one of two ways: “general emergencies” and “public health emergencies.” General emergency laws allow for a declaration of a “general emergency” or “disaster.” Nearly every State has developed a legal structure for declaring a “general emergency” or “disaster” and the provisions authorize the State to engage in related emergency management functions. More recently, some States have enacted statutes that allow for the declaration of a “public health emergency.” Public health emergency laws provide for emergency planning and response actions that may be taken specifically to prepare for and respond to emergencies that threaten the public’s health. See the Legal and Regulatory Issues Report, Section 3.1 for more information on emergency declarations.

In the States that authorize “general emergency” and “public health emergency” declarations, both declarations may be invoked simultaneously or overlapped. The resulting “dual declaration” scenario may create confusion over who is in charge of emergency responses and what powers, duties, and protections are in place. The uncertainty created by dual declarations may have practical consequences on responders as well. Depending on the declaration, differing State or local agencies may be legally responsible for coordinating responses, and differing requirements for liability protection and licensure waiver may apply.

Volunteers within an ESAR-VHP System may be called to help through different State or local agencies depending on the nature of the declared emergency. Advance planning and discussions concerning the appropriate uses of health volunteers during emergencies may help to avoid potential confusion or overlapping claims, and may be needed to maximize the utility of the ESAR-VHP System.

### **9.3.2 *Civil Liability Issues***

Civil liability arises when a person or entity is found to have caused injury or damage to another and is required by law to compensate the person or persons harmed. Individuals and entities participating in or organizing an ESAR-VHP System, such as health volunteers, organizational entities accepting or providing health volunteers, and entities administering the ESAR-VHP System may face civil liability under certain circumstances. For example, health volunteers may be civilly liable for negligently providing medical care and treatment during an emergency.

All States offer health volunteers some degree of immunity from civil liability, depending on the circumstances. Volunteer protection statutes and governmental immunity provisions may grant immunity to health volunteers working as employees or agents of the government. During emergency situations, additional legal sources of immunity may be available including Good

Samaritan statutes, emergency declaration statutes, and mutual aid compacts. See the Legal and Regulatory Issues Report, Section 3.3.1 for additional discussion and helpful tables referencing relevant statutes in select States.

Organizational entities may also face liability for their own negligent actions or even for the actions of their employees or health volunteers. Organizations do not typically qualify for immunity under the statutes that grant an individual's immunity from liability. See the Legal and Regulatory Issues Report, Section 3.3.2 for additional information. A clear understanding of the civil liability implications for ESAR-VHP System participants is vital to the successful implementation of the System.

### *9.3.3 Workers' Compensation*

Workers' compensation provides limited benefits to victims of work-related injuries or death, regardless of fault. Each State (and the federal government) has enacted workers' compensation laws, which require work-related injuries to be reported and compensated in accordance within specific guidelines. The application of workers' compensation benefits to health volunteers participating in an ESAR-VHP System raises a host of questions discussed fully in the Legal and Regulatory Issues Report, Section 3.4. Two important legal questions include (1) do workers' compensation laws apply to volunteers as if they were "employees"? and (2) if volunteers are considered to be employees, who is employing them and is therefore responsible for providing workers' compensation coverage?

As a general matter, workers' compensation laws only cover "employees," and thus exclude unpaid volunteers or gratuitous workers. Some States extend explicit coverage to certain volunteer workers through specific legislation. Absent such provisions or other agreements, volunteers may not receive coverage.

A second major challenge is determining who during an emergency is "employing" a volunteer worker. A volunteer's existing employer may not be liable for injuries the volunteer sustains when providing services elsewhere if the volunteer's action is outside his or her course of employment. This may be the case if the volunteer leaves his or her regular place of employment or crosses State lines to provide services. Some States' laws indicate that health volunteers are considered to be State employees for the duration of an emergency. In the event that a statute defines health volunteers as employees, but does not define the State or municipality as the employer, it may be concluded that the hospital or institution for which health volunteers are temporarily working could be considered the employer for workers' compensation purposes. See the Legal and Regulatory Issues Report, Section 3.4 for more information on workers' compensation.

### *9.3.4 Licensure, Credentialing, and Privileging Requirements*

State laws generally require health professionals, practicing within a State, to have obtained appropriate professional licensure or similar official certification. In certain settings, health professionals may also be required to meet credentialing and privileging requirements. The processes of licensing, credentialing, and privileging are unique from each other, but each serves an important role in fostering quality control in the provision of health care. Since these

processes are normally time-intensive and deliberate, meeting the legal and non-legal requirements and standards in emergency situations may be challenging.

Under circumstances where the ESAR-VHP System is utilized, additional health professionals from other States may be needed to respond. The participation of qualified health professionals is no less important during an emergency, yet the urgency of the situation may not allow for the normal professional evaluation procedures. Therefore, it is imperative that States understand the legal and practical ramifications of using health volunteers that are not licensed in the State. Some States have implemented legal provisions that allow for the usual licensure, credentialing, and privileging requirements to be waived during an emergency. Other States have authorized general license reciprocity to facilitate cross-border practice through mutual compacts or agreements. Furthermore, JCAHO requirements mandate that hospitals must provide for temporary and disaster privileging of health professionals. See the Legal and Regulatory Issues Report, Section 3.2, for additional information on the legal impact of licensing, credentialing, and privileging requirements of an ESAR-VHP System.

#### *9.3.5 Criminal Liability Issues*

States should be aware of the applicability of criminal laws to acts committed by volunteer health professionals. Criminal responsibility may apply to the actions of a volunteer health professional that satisfies the elements of the crime he is alleged to have committed, as defined by state or federal law. A volunteer health professional, for example, who intentionally tries to harm patients during an emergency, could face multiple criminal charges (just the same as the volunteer would face during non-emergencies). State laws do not explicitly offer immunity from criminal liability, but some State or federal laws may potentially insulate an individual from criminal responsibility. See the Legal and Regulatory Issues Report, Section 3.5 for additional discussion of criminal liability issues.

#### *9.3.6 Use of ESAR-VHP System Information*

When planning an ESAR-VHP System, States must have a clear understanding as to how existing information privacy laws may limit the type of information that may be collected about a health volunteer, and the process by which the information is collected. Privacy laws may limit or prohibit the ability to gather, maintain, or share certain credentialing or other personal information (e.g., identifiable health information) on health volunteers that may be required to perform ESAR-VHP functions. Many State and local privacy laws allow for the acquisition, use, and disclosure of identifiable data related to volunteer health professionals, provided that specific, written informed consent is obtained. See the Legal and Regulatory Issues Report, Section 3.6.1 for further discussion about privacy issues related to information in the ESAR-VHP System.

#### *9.3.7 Dispatching Volunteers*

The administrative control of the ESAR-VHP System should remain with the entity responsible for deploying and coordinating the resources in the event of an emergency. The State entity or delegated authority responsible for coordinating health volunteers during an emergency may not be clear. To avoid ambiguities, the State must define the authority responsible and accountable for coordinating and commanding health volunteer resources.

While the State may find it appropriate to utilize the ESAR-VHP System in cases outside those involving a formally declared State emergency, use of the ESAR-VHP System in such circumstances should be clearly differentiated to avoid confusion about applicable legal protections. Emergency powers and legal protections that are in effect during a declared State emergency may not be applicable during an emergency response instigated at the local level.

#### **9.4 Delegation of Power to Administer Primary ESAR-VHP Functions**

Once formal State authority is in place to establish an ESAR-VHP System, the State may properly delegate, to local authorities or other entities, power to administer primary functions of the System previously described in the System Design section. The ESAR-VHP System functions include registration, applying emergency credentialing standards, and emergency verification.

##### **9.4.1 Registration**

This function includes collecting and maintaining a health volunteer's registration information, which includes consent to participate in the ESAR-VHP Program. The State may register health volunteers directly into the ESAR-VHP System, work in concert with volunteer programs to register health volunteers, or both.

To take advantage of existing efforts and capabilities, the State may find it highly beneficial to work closely with existing volunteer organizations that routinely register and maintain information on health volunteers. The State must establish a process by which participating members of the existing programs register in the State ESAR-VHP. If a member of a selected volunteer program chooses not to participate in the ESAR-VHP, the members' ability, and hence the volunteer unit's ability, to provide health services outside their own local jurisdiction during an emergency may be jeopardized. Volunteer programs may register and recruit volunteers as they have always done, however, with additional integration into a central ESAR-VHP System.

##### **9.4.2 Emergency Credentialing**

This function assigns an emergency credentialing level based on verified credential information for health volunteers. The application of emergency credentialing standards is administered by the State or by a properly delegated authority under supervision of the State. Collecting and verifying a health volunteer's credentials and assigning an appropriate emergency credentialing level is at the heart of the State's role with the ESAR-VHP System. Further, emergency credentialing standards are vital to cross-jurisdictional mobilization of volunteers, which would be coordinated at the State level (as discussed above).

##### **9.4.3 Emergency Verification**

This function serves to verify the health volunteer's information and authorize the use of that information in an emergency. While emergency verification may be performed in a number of ways, it is recommended that the State perform this function as well as controlling authorization to access and use the ESAR-VHP System. The use of an ESAR-VHP System in an emergency assumes that formal systems of coordination and a chain of command are maintained to support System use between receiving agencies and State, or State-delegated authorities. The processes that permit access to volunteer information and the ability to dispatch and deploy volunteers are closely related and should be carefully controlled by the State.

## **9.5 Determining the Appropriate Protocols for ESAR-VHP System Use**

The ability to use the ESAR-VHP System must rest at the State level or be properly delegated by the State to a specific authority. There are two principal reasons for coordinating the use of the ESAR-VHP System at the State level rather than at the local level. First, the ESAR-VHP System must be useful in a multi-jurisdictional response scenario, whether intrastate or interstate. In an intrastate scenario, local jurisdictions operating independent volunteer systems may not be able to effectively coordinate the sharing of volunteer professionals between local jurisdictions. Second, local jurisdictions may not have consistent legal protections in place to ensure the successful operation of the System. Most States, however, will find it desirable to delegate the authority to allow System use by proper local authorities to support intrastate mutual aid structures for local emergency needs. When delegating this authority, it is imperative that the State establish clear protocols and procedures for use of the ESAR-VHP System.

During interstate emergency use of an ESAR-VHP System, local jurisdictions rarely have the authority to invoke legislative and mutual aid mechanisms such as Emergency Management Assistance Compacts (EMAC), which may only be activated by the State's highest executive, typically the Governor. Under EMAC and other similar State-level mutual aid agreements, all resource requests, including health volunteers, must be coordinated at the State level. Local jurisdictions may, however, enter into mutual aid agreements that do not require State approval.

An ESAR-VHP System must be operational, though not necessarily activated, at the time the State declaration of emergency is announced. Under State law, government officials are empowered to declare an emergency for disasters and public health crises. As discussed above, emergency declarations grant additional powers and duties to the Governor, emergency management, public health, or public safety authorities. These powers may govern the use and command of personnel, including health professionals who volunteer their services, as well as related issues such as volunteer and institutional liability, and workers' compensation for health volunteers. See the additional discussion of these issues above and in the Legal and Regulatory Issues Report, Section 3.0 for more information.

## **9.6 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Identify effective approaches for State delegation of ESAR-VHP functions to local authorities.
- Identify protocols for State-to-State coordination during an emergency.
- Evaluate the suitability of State and local laws to authorize an ESAR-VHP System.



## 10.0 System Operations and Maintenance

### 10.1 Overview of System Operations and Maintenance

This section describes the recommended System operations and maintenance issue items for States.

*Recommended items in this section:*

- 10.2 Assign position of technical System Administrator with responsibilities including:
  - 10.2.1 Verifying and updating volunteer information.
  - 10.2.2 Establishing information redundancy and back-ups.
  - 10.2.3 Coordinating System use in an emergency.
- 10.3 Review issues with integration of identification cards into ESAR-VHP Systems.
- 10.4 Review Future Focus Areas and Needs of the National ESAR-VHP Program.

The following terms are referenced in this section:

*System Administrator* is a position responsible for the operation and maintenance of the ESAR-VHP System.

*System Coordinator* is a position responsible for overseeing, directing, or assisting in the guidance of the overall activities of the ESAR-VHP System, including coordinating System use in a declared emergency.

### 10.2 Assigning a Technical System Administrator and the Responsibilities of a System Administrator

It is imperative to have competent personnel overseeing the technical operations of an ESAR-VHP System on a daily basis, as well as providing necessary technical support in an emergency situation. This position may be filled by a special individual, the System Coordinator, or be assigned to technically competent personnel.

The primary responsibility of a System Administrator is the maintenance and coordination of accurate and timely information within the System. Responsibilities may also include reviewing and approving volunteer credential information and making the appropriate changes in the System. Additionally, the System Administrator may oversee support staff and facilitate System training to all those authorized to use the ESAR-VHP System. In emergency situation, the System Administrator may need to provide technical troubleshooting to ensure that the System remains operational.

The System Administrator's responsibilities must include:

- Coordinating the technical and operational logistics necessary to maintain accurate and timely System information.
- Setting policies for the frequency of data verification with primary sources.
- Ensuring the accuracy of health volunteer data.

In addition the System Administrator's responsibilities may also include:

- Reviewing and approving volunteer credential information and making the appropriate changes in the System.
- Overseeing support staff and facilitating operational training for authorized individuals.
- Providing technical support to ensure the System remains operational in an emergency situation.

#### *10.2.1 Verifying and Updating Volunteer Information*

Depending on the specific configuration of a State ESAR-VHP System, assembling and verifying data may be time consuming and require both electronic and manual business processes. Since these processes could potentially involve multiple primary source databases, a State must factor in the time and resource demands on the System during the budgeting process.

The System Administrator will have to set policies for the frequency of data verification with primary sources. The System Administrator is also responsible for administering the information used to determine emergency credentialing levels. The credential information utilized to determine a health volunteer's emergency credentialing level should be verified, at a minimum, on an annual basis. Therefore, all emergency credentialing levels should be checked and potentially changed on an annual basis. Following the Guidelines testing period, a requirement may be set governing the frequency of credential information and emergency credentialing level updates.

The System should be designed to allow health volunteers to update their information, such as legal residence, contact information, additional training, or professional specialty updates. One effective mechanism utilized by some existing ESAR-VHP models includes sending email reminders on a quarterly or semi-annual basis to prompt health volunteers to review and update their information.

Once health volunteer authorizations and acknowledgement information is collected upon registration, a health volunteer should have the ability to change or modify authorizations or have his or her health volunteer records taken out of an ESAR-VHP System promptly.

A health volunteer must be able to review or modify personal information. To have current information on a health volunteer, the health volunteer should be prompted to review his or her information and make any needed changes on at least an annual basis.

#### *10.2.2 Establishing Information Redundancy and Back-ups*

As with any electronic system, the potential for downtime exists. In the event of a disaster, it is possible that network systems will not be accessible and the ESAR-VHP System must revert to paper or stand-alone digital back-up systems. Additionally, the risk of purposeful or accidental data deletion or loss also exists. A coherent back-up strategy is therefore necessary to ensure continuity and accessibility of information. As discussed in the Security and Privacy section, all copies of ESAR-VHP information must be stored in a secure manner.

Regular back-ups of System information and applications are essential. No matter what kind of back-up media is used (e.g. tape, hard disk), it is important to make regular, complete back-ups of the System preferably daily, or, at a minimum, multiple times per week. It is imperative that the software and hardware operations of the System can be recreated if technical problems arise.

Once a System's information and applications are backed up, it is important to store copies of the System back-ups both locally and off-site. System back-ups should be stored in a protected area so that critical data remains secure and private. It is also important to prevent against the failure of a specific component or pieces of hardware in the System. This can be accomplished by using multiple servers to deliver and store information for the ESAR-VHP System.

Physical integrity of the System is also important. ESAR-VHP Systems should be hosted in facilities with back-up power and redundant network connections. However, even with these safeguards in place, a major disaster may cause an entire data center to go offline. In this case, redundant servers located in geographically different areas and connected to separate power grids and data networks are the best defense against failure. In this scenario, if the primary System fails, there is a wholly separate System that contains the same information, which can automatically switch over or be brought online depending on the setup. Additionally, regular printing of paper back-up copies of information allows for recovery in the event of a total system loss.

### *10.2.3 Coordinating System Use in an Emergency*

In the event of a general or public health emergency the State ESAR-VHP System will be activated to help properly dispatch health volunteers. In the event of such a declaration, the System Coordinator will have control of the technical administration of the ESAR-VHP System, and will delegate appropriately. Communication between System Coordinators may be required if out-of-state health volunteers are needed.

Based on the surge of activity in an emergency, additional personnel will likely be required to coordinate ESAR-VHP activities, potentially throughout the State. Incident commanders must be made aware and trained on the processes involved in utilizing the ESAR-VHP and requesting health volunteers.

## **10.3 Integration of Identification Card with ESAR-VHP Systems**

There are a range of issues associated with ID cards or other media used to verify identities of health volunteers deployed by ESAR-VHP Systems. These issues will be closely examined during the Guidelines testing period. Because credential information and emergency credentialing levels may change and the potential for ID card forgery, additional steps should be employed to verify the health volunteer's information with the ESAR-VHP System. Also, an existing ID card, such as a driver's license, if not modified to incorporate ESAR-VHP information, will not provide any advantage for emergency authorities when seeking to access ESAR-VHP information. To transmit information between States effectively, ID cards should come from a State authority or widely recognized authority.

As stated, an identification card which is integrated into the ESAR-VHP System allows for the proper identification of health volunteers in an emergency and facilitates the verification of health volunteer information from an ESAR-VHP System. Additionally, the State may streamline the application process for ID card issuance by automating the process through the ESAR-VHP System. If possible, it is also advantageous to provide instructions for authenticating the cards, such as having information on a web address or a telephone number to access additional information on the health volunteer.

When a health volunteer arrives on-site, an identification card may serve to replace documentation that would otherwise be necessary to establish basic credentials. A State may utilize existing ID card systems, such as drivers' licenses, to verify identity or create a new ID card program. If a State does not establish a common ID card for use by a health volunteer participating in an ESAR-VHP System, the State should establish State-wide standards on methods by which health volunteers identities are verified during an emergency using existing identification means.

One existing model addresses volunteer deployment using existing identification methods. When a volunteer arrives on-site, the volunteer must present a current, valid professional license and one of the following:

- A valid photo ID issued by a State, federal or regulatory agency
- A current hospital photo identification card
- A Disaster Medical Assistance Team (DMAT) identification card
- Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity

Once a health volunteer's identity is verified, receiving authorities must then verify the health volunteer's ESAR-VHP information. The identification card serves to confirm identity and provide minimal credential and emergency credentialing standards. In an emergency scenario, an ID card with some level of information integration with the State's ESAR-VHP System, such as current ESAR-VHP information in common formats on an ID card, will be beneficial. A receiving entity should not rely solely on the identification card when determining whether to authorize the services of the health volunteer. To properly utilize the health volunteer's services, formal verification of the health volunteer's information should take place against the most currently available information in an ESAR-VHP System.

### *10.3.1 Information on an ESAR-VHP Card*

The information an ID card used in conjunction with an ESAR-VHP System should contain:

- Issuing authority
- Color photograph
- Full name
- Professional discipline
- Professional licensure and emergency credentialing information and level
- Date of card issuance
- Unique identification number

States should exert the same level of caution when issuing ID cards to support its ESAR-VHP Systems as would be given to other forms of State-issued identification cards.

## **10.4 Future Focus Areas and Needs of the National ESAR-VHP Program**

- Determine effective protocols for System use in an emergency, including differentiating levels of use.
- Prepare a testing methodology to determine frequency of back-ups and volunteer information validations.
- Examine the issue of ID cards further. The areas of interest will include:
  - a. Identification card layout and design
  - b. Potential alternatives for identification media
  - c. Potential use of encoded information on cards and machine readable technologies



## **11.0 Regionalizing and Nationalizing the ESAR-VHP Program**

### **11.1 Overview of Regionalizing and Nationalizing the ESAR-VHP System**

This section describes the future activities of the ESAR-VHP Program in directly evaluating State-to-State use of ESAR-VHP Systems in an emergency. The lessons learned will be included in future versions of the Guidelines.

The major function of the national working group addressing the subject of regionalizing and nationalizing the ESAR-VHP Systems will be to perform a tabletop test of the Guidelines with two interstate regions.

Two regions are designated as for the evaluation of ESAR-VHP Systems to accommodate State-to-State use:

- Missouri and Illinois
- West Virginia, Virginia, and Washington, D.C.

Effective protocols and approaches for regional and national use of the ESAR-VHP Systems will gradually develop over the life of the project. A key consideration during ESAR-VHP development will be the integration with the nation's systems for incident command, as embodied by National Incident Management System (NIMS), the nation's mutual aid structure, represented by EMAC, and other interstate mutual aid structures and legal structures designed to facilitate mobilization of health volunteers across jurisdictions.



## 12.0 Data Definitions

### 12.1 Overview of Data Definitions

The Guidelines describe the data elements and related data definitions required or recommended to be collected and used by an ESAR-VHP System. The data definitions associated with each data element are provided throughout this section. For the benefit of System Administrators, the tables below are oriented to assist with web-based ESAR-VHP System implementation.

Required Data Definition items are:

- 12.2 Determine health volunteer identification information needs.
- 12.3 Determine health volunteer authorization and acknowledgement information needs.
- 12.4 Determine credential and Emergency Credentialing Level information needs.
- 12.5 Occupation: Physician.
- 12.6 Occupation: Registered Nurse
- 12.7 Occupation: Marriage and Family Therapist
- 12.8 Occupation: Medical and Public Health Social Worker
- 12.9 Occupation: Mental Health and Substance Abuse Social Worker
- 12.10 Occupation: Psychologist
- 12.11 Occupation: Mental Health Counselor

The following terms are referenced in this section:

*A data element* is a stored element within a database that is associated with a health volunteer record.

*A data definition* is the description of the data attributes that identify a data element.

*A health volunteer record* is the complete set of information maintained on the health volunteer by the ESAR-VHP System. Each health volunteer's record must be accessible by the System Administrator. A health volunteer record contains the health volunteer's registration information, credential information, emergency credentialing level information, and other supporting information.

### 12.2 Determining Health Volunteer Identification Information Needs

The data elements defined in this data set are used to verify a registrant's identity and assist in the collection and verification of additional credentialing information as well as facilitate identification and check-in at an emergency staging area.

Identification Information		
	Category	Data Element
1	E-mail	Primary E-mail
2	Name	Prefix
3		First Name
4		Middle Initial

5		Last Name
6		Suffix
7		Alias
8	Residence	Legal Residence Line 1
9		Legal Residence Line 2
10		City
11		State
12		Zip Code
13	Personal Attributes	Social Security Number
14		Birth Date
15		Gender
16		Height
17		Weight
18		Hair Color
19		Eye Color
20		Languages Spoken
21	ESAR-VHP ID Number	ESAR-VHP ID Number

- 1) The primary e-mail address at which the health volunteer prefers to be contacted.
- 2) Any titles that precede the health volunteer's first name.
- 3) The legal first name of the health volunteer.
- 4) The first letter of the health volunteer's middle name.
- 5) The legal last name of the health volunteer.
- 6) Any titles that follow the health volunteer's last name.
- 7) Other names by which health volunteer is known.
- 8) The first line of the health volunteer's legal address.
- 9) An optional second line of the health volunteer's legal address.
- 10) The city in which the health volunteer resides.
- 11) The State in which the health volunteer resides. See Appendix 10 for a list of States and territories.
- 12) The zip code of the city, State in which the health volunteer resides.
- 13) The health volunteer's Social Security Number.
- 14) The date the health volunteer was born.
- 15) The gender of the health volunteer (Male | Female).
- 16) The height of the health volunteer (Feet: 3 | 4 | ... | 6 | 7 - Inches: 0 | 1 | ... | 10 | 11).
- 17) The weight of the health volunteer in pounds.
- 18) The color of the health volunteer's hair (Black | Brown | Blonde | Grey | Red | White | Bald).
- 19) The color of the health volunteer's eyes (Black | Brown | Blue | Gray | Green | Hazel | Dichromatic | Albino)
- 20) Fluency level in any languages other than English of the health volunteer. Contact support@esarvhp.com for a list of common languages.
- 21) If a State has not already assigned unique identification numbers for use with an ESAR-VHP System, the State should establish an identification number consisting of 11 numeric characters that each health volunteer would be assigned. The first two digits would identify the State in which the health volunteer is registered, and the remaining nine digits would

identify the record within the State. System Administrators seeking assistance on implementing the ESAR-VHP ID Number should contact [support@esarvhp.com](mailto:support@esarvhp.com).

### 12.3 Determining Health Volunteer Authorizations and Acknowledgements Information Needs

The data elements defined in this data set include authorizations and acknowledgements given by the health volunteer to the ESAR-VHP System to collect and maintain his or her information. The information collected in this data set is imperative to supporting the System Registration function.

Authorizations and Acknowledgements Information		
	Category	Data Element
22	Information Usage	Consent
23		Pledge
24		Background Check Consent
25		Consent/Pledge Date
26	Deployment	Geographical Deployment Preference
27		Travel Distance
28		Deployment Time
29		Incident Type
30		Federal Participation Willingness

- 22) Confirms that a health volunteer has consented to a State collecting, using, and maintaining his/her personal information (Yes | No).
- 23) The pledge a health volunteer gives to offer only correct information (Yes | No).
- 24) The volunteer's consent to allow the State to perform reference and background checks.
- 25) The date, whether entered by a System Administrator or automatically by the System, the volunteer consented to be considered a potential health volunteer.
- 26) Deployment preference for a health volunteer (Local | State | Out-of-State).
- 27) Distance (in miles) from their legal residence that a health volunteer is willing to be deployed (0-25 | 26-50 | 51-100 | 101-500 | >500).
- 28) Time (in days) that a health volunteer is willing to be on deployment (0-10 | 11-30 | 31-90 | 91-180 | >180).
- 29) Type of incident in which a health volunteer is willing to respond (TBD).
- 30) In the event of a declared national emergency, would you consider volunteering to work under the auspices of the Federal Government? If you check yes, in the event of a national emergency, the information you provide will made available to the Federal Government upon its request (Yes | No).

### 12.4 Determining Credential and Emergency Credentialing Level Information Needs

The data elements defined in this data set are used to determine a health volunteer's emergency credentialing level and may include relevant education and professional training, licensure, certification, and clinical practice information. The data definitions for data elements necessary to apply Emergency Credentialing Standards will be evaluated during the Guidelines testing period. Data definitions will be provided for physicians, registered nurses, and for specific

behavioral health professions, including psychologists, social workers, and therapists, as described in the Emergency Credentialing Standards section.

To set an emergency credentialing level, the System must collect necessary credential information for each occupation, as described in the Emergency Credentialing Standards section.

### *Occupation*

An occupation is a health volunteer's principle health profession, such as physician, registered nurse, psychologist, or pharmacist. A health volunteer may select multiple disciplines alongside his or her profession. The specific professions included under the 'select' are being evaluated and are forthcoming. The initial professions, or occupations, are physician, registered nurse, psychologist, social worker, and therapist.

<b>Occupational Discipline Information</b>		
	<b>Category</b>	<b>Data Element</b>
31	Occupation	Occupation Discipline

- 31) The primary occupational discipline of the health volunteer (Medical Doctor/Doctor of Osteopathy | Registered Nurse | Marriage & Family Therapist | Medical & Public Health Social Worker | Mental Health & Substance Abuse Social Worker | Psychologist | Mental Health Counselor).

## **12.5 Occupation: Physician.**

A physician is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who, by virtue of education, training and demonstrated competence, is fully licensed to practice medicine and may be granted clinical privileges by a health care organization to perform specific diagnostic or therapeutic procedures.

<b>M.D./D.O.</b>		
	<b>Category</b>	<b>Data Element</b>
32	State License	Licensee Name
33		License Number
34		License Type
35		State
36		Expiration Date
37		Good Standing Question
38		Adverse Actions Question
39	ABMS/AOA Certification	Specialty
40		Expiration Date
41		Specialty
42		Expiration Date
43		Specialty
44		Expiration Date
45	ABMS/AOA Eligible	Hospital Name

46	Active Clinical Practice (non-hospital)	Organization Name
47		Organization City
48		Organization State
49		Start Date
50	Active Hospital Privilege	Hospital Name
51		Hospital City
52		Hospital State
53		Specialty(ies) Practiced
54	National Practitioner Databank Status	Malpractice Question
55	DEA License	License Number
56		Expiration Date
57		Fraud Question
58	Residency Training Information	Supervisor Name
59		Organization Name
60		Organization City
61		Organization State
62		Specialty
63		Completion Date
64	Medical Degree	Degree Type
65		Institution Name
66		Institution City
67		Institution State
68		Conferred Date
69	International Medical Graduate	ECFMG Number
70		Issue Date
71	Inspector General Status	Fraud Question

- 32) The health volunteer's exact name as it appears on the license.
- 33) The unique license number.
- 34) The type of license a health volunteer possesses (M.D. | D.O.).
- 35) The State which issued the license. See Appendix 10 for a list of States and territories.
- 36) The expiration date of the license.
- 37) Question: "Is your license in good standing?"
- 38) Question: "Are there any adverse actions or restrictions associated with your license?"
- 39) The type of specialty granted by the American Board of Medical Specialties. See Appendix 3 for a list of specialties.
- 40) The date which the specialty issued by the American Board of Medical Specialties expires.
- 41) The type of specialty granted by the American Board of Medical Specialties. See Appendix 3 for a list of specialties.
- 42) The date which the specialty issued by the American Board of Medical Specialties expires.
- 43) The type of specialty granted by the American Board of Medical Specialties. See Appendix 3 for a list of specialties.
- 44) The date which the specialty issued by the American Board of Medical Specialties expires.

- 45) The name of the hospital at which the health volunteer is eligible to practice.
- 46) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 47) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 48) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 49) The date which the health volunteer started practicing active clinical work at the non-hospital organization.
- 50) The name of the hospital at which the health volunteer has active privileges.
- 51) The city of the hospital where the health volunteer has active privileges.
- 52) The State of the hospital where the health volunteer has active privileges. See Appendix 10 for a list of States and territories.
- 53) The health volunteer's area of specialty(ies) practiced at the hospital where he/she has active privileges.
- 54) Question: "Have you ever had an adverse action associated with your license?"
- 55) The health volunteer's DEA license number.
- 56) The date which the health volunteer's DEA license expires.
- 57) Question: "Have you ever surrendered or had a federal controlled substance registration revoked, suspended, restricted, or revoked?"
- 58) The name of the supervisor at which the health volunteer performed his/her residency.
- 59) The name of the organization at which the health volunteer performed his/her residency.
- 60) The city in which the health volunteer performed his/her residency.
- 61) The State in which the health volunteer performed his/her residency. See Appendix 10 for a list of States and territories.
- 62) The area of specialization the health volunteer experienced during his/her residency.
- 63) The date which the health volunteer completed his/her residency.
- 64) The type of degree the health volunteer possesses (M.D. | D.O.).
- 65) The name of the institution at which the health volunteer attained the degree.
- 66) The city of the institution at which the health volunteer attained the degree.
- 67) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 68) The date the degree was conferred.
- 69) The number issued by the Educational Commission for Foreign Medical Graduates.
- 70) The date which the ECFMG number was issued to the health volunteer.
- 71) Question: "Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participating in federal or state health care programs?"

## 12.6 Occupation: Registered Nurse

A registered nurse (RN) has passed a State registration examination and has been licensed to practice as a registered nurse. The registration license is intended to ensure minimum levels of competence and thus protect the public, not to indicate the educational background of a nurse.

RN		
	Category	Data Element

72	State License	Licensee Name
73		License Number
74		State
75		Expiration Date
76		Good Standing Question
77		Adverse Actions Question
78	Certification	Specialty
79		Organization
80		Issue Date
81		Expiration Date
82	Active Clinical Practice	Supervisor Name
83		Clinical Setting
84		Organization Name
85		Organization City
86		Organization State
87		Area of Practice
88		Start Date
89	Degree	Degree Type
90		Educational Institution Name
91		Educational Institution City
92		Educational Institution State
93		Conferred Date
94	Specialized Experience	Specialty
95		Years of Specialty Experience
96	Inspector General Status	Fraud Question

- 72) The health volunteer's exact name as it appears on the license.
- 73) The unique license number.
- 74) The State which issued the license. See Appendix 10 for a list of States and territories.
- 75) The expiration date of the license.
- 76) Question: "Is your license in good standing?"
- 77) Question: "Are there any adverse actions or restrictions associated with your license?"
- 78) The area of specialization the health volunteer possesses. See Appendix 7 for a list of specialties.
- 79) The name of the organization which awarded the specialization. See Appendix 7 for a list of organization names.
- 80) The date the certification was issued to the health volunteer.
- 81) The date the certification is no longer valid.
- 82) The name of the supervisor where the health volunteer actively practices.
- 83) The physical setting in which the health volunteer practices his/her active clinical work (Hospital | Private or Group Practice | Clinic | Public Health).
- 84) The name of the organization in which clinical practice occurs.
- 85) The city in which the organization is located where the health volunteer practices active clinical work.
- 86) The State in which the organization is located where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.

- 87) The area of practice a health volunteer may specialize in.
- 88) The date in which the health volunteer started active clinical work with this organization.
- 89) The type of degree which the health volunteer possesses.
- 90) The name of the institution at which the health volunteer attained the degree.
- 91) The city of the institution at which the health volunteer attained the degree.
- 92) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 93) The date the degree was conferred.
- 94) The health volunteer's area of specialty based solely on experience.
- 95) The number of years the health volunteer has practiced his/her specialty.
- 96) Question: "Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participating in federal or state health care programs?"

## 12.7 Occupation: Marriage and Family Therapist

A marriage and family therapist is a mental health professional who is trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems. Marriage and family therapists have graduate training (a Master's or Doctoral degree) in marriage and family therapy and at least two years of clinical experience.

Marriage and Family Therapist		
	Category	Data Element
97	State License	Licensee Name
98		License Number
99		State
100		Expiration Date
101		Good Standing Question
102		Adverse Actions Question
103	AAMFT Examination	AAMFT Question
104	Active Clinical Practice	Organization Name
105		Organization City
106		Organization State
107		Clinical Setting
108		Start Date
109	Previous Clinical Experience	Supervisor Name
110		Organization Name
111		Organization City
112		Organization State
113		Clinical Setting
114		Start Date
115		End Date
116	Post-graduate Degree	Degree Type
117		Conferred Date
118		Institution Name

119		Institution City
120		Institution State

- 97) The health volunteer's exact name as it appears on the license.
- 98) The unique license number.
- 99) The State which issued the license. See Appendix 10 for a list of States and territories.
- 100) The expiration date of the license.
- 101) Question: "Is your license in good standing?"
- 102) Question: "Are there any adverse actions or restrictions associated with your license?"
- 103) Question: "Did you successfully complete the American Association for Marriage and Family Therapy Examination?"
- 104) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 105) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 106) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 107) The type of setting the health volunteer actively practices in (Hospital | Private or Group Practice | Clinic | Public Health).
- 108) The date which the health volunteer started practicing active clinical work at the non-hospital organization.
- 109) The name of the supervisor where the health volunteer had done previous clinical work.
- 110) The name of the organization at which the health volunteer had previously performed clinical work.
- 111) The city in which the organization, where the health volunteer had previously performed clinical work, is located.
- 112) The type of setting the health volunteer gained previous experience in (Hospital | Private or Group Practice | Clinic | Public Health).
- 113) The State in which the organization, at which the health volunteer had previously performed clinical work, is located. See Appendix 10 for a list of States and territories.
- 114) The date which the health volunteer started performing clinical work at this organization.
- 115) The date which the health volunteer finished performing clinical work at this organization.
- 116) The type of post-undergraduate degree which the health volunteer possesses.
- 117) The date the degree was conferred.
- 118) The name of the institution at which the health volunteer attained this degree.
- 119) The city in which the institution, at which the health volunteer attained this degree, exists.
- 120) The State in which the institution, at which the health volunteer attained this degree, exists. See Appendix 10 for a list of States and territories.

## 12.8 Occupation: Medical and Public Health Social Worker

Medical and public health social workers (MPHSW) provide persons, families, or vulnerable populations with the psychosocial support needed to cope with chronic, acute or terminal illnesses, such as Alzheimer's disease, cancer, or AIDS. They also advise family caregivers, counsel patients, and help plan for patients' needs after discharge by arranging for at-home services from Meals on Wheels to oxygen equipment. Some work on interdisciplinary teams that evaluate certain kinds of patients, for example, geriatric or organ transplant patients.

Medical and public health social workers may work for hospitals, nursing and personal care facilities, individual and family services agencies, or local governments.

<b>Medical and Public Health Social Worker</b>		
	<b>Category</b>	<b>Data Element</b>
121	State License	Licensee Name
122		License Number
123		State
124		Expiration Date
125		Good Standing Question
126		Adverse Actions Question
127	Degree	Degree Type
128		Educational Institution Name
129		Educational Institution City
130		Educational Institution State
131		Conferred Date
132	NASW Credentials	Credential Name
133		Expiration Date
134	NASW Certification	Specialty Name
135		Expiration Date
136	Active Clinical Practice	Organization Name
137		Organization City
138		Organization State
139		Clinical Setting
140		Start Date
141	Inspector General Status	Fraud Question

- 121) The health volunteer's exact name as it appears on the license.
- 122) The unique license number.
- 123) The State which issued the license. See Appendix 10 for a list of States and territories.
- 124) The expiration date of the license.
- 125) Question: "Is your license in good standing?"
- 126) Question: "Are there any adverse actions or restrictions associated with your license?"
- 127) The type of degree the health volunteer possesses.
- 128) The name of the institution at which the health volunteer attained the degree.
- 129) The city of the institution at which the health volunteer attained the degree.
- 130) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 131) The date the degree was conferred.
- 132) The type of credential awarded by the National Association of Social Workers. See Appendix 6 for a list of credentials.
- 133) The expiration date of the credential awarded by the National Association of Social Workers.
- 134) The type of certification awarded by the National Association of Social Workers. See Appendix 6.

- 135) The expiration date of the certification awarded by the National Association of Social Workers.
- 136) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 137) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 138) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 139) The type of setting the health volunteer actively practices in (Hospital | Private or Group Practice | Clinic | Public Health).
- 140) The date which the health volunteer started practicing active clinical work at the non-hospital organization.
- 141) Question: “Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participating in federal or state health care programs?”

## 12.9 Occupation: Mental Health and Substance Abuse Social Worker

Mental health and substance abuse social workers (MHSASW) assess and treat individuals with mental illness, or substance abuse problems, including abuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They may also help plan for supportive services to ease patients’ return to the community. Mental health and substance abuse social workers are likely to work in hospitals, substance abuse treatment centers, individual and family services agencies, or local governments. These social workers may be known as clinical social workers.

Mental Health and Substance Abuse Social Worker		
	Category	Data Element
142	State License	Licensee Name
143		License Number
144		State
145		Expiration Date
146		Good Standing Question
147		Adverse Actions Question
148	Degree	Degree Type
149		Educational Institution Name
150		Educational Institution City
151		Educational Institution State
152		Conferred Date
153	NASW Credentials	Credential Name
154		Expiration Date
155	NASW Certification	Specialty Name
156		Expiration Date
157	Active Clinical Practice	Organization Name
158		Organization City

159		Organization State
160		Clinical Setting
161		Start Date
162	Inspector General Status	Fraud Question

- 142) The health volunteer's exact name as it appears on the license.
- 143) The unique license number.
- 144) The State which issued the license. See Appendix 10 for a list of States and territories.
- 145) The expiration date of the license.
- 146) Question: "Is your license in good standing?"
- 147) Question: "Are there any adverse actions or restrictions associated with your license?"
- 148) The type of degree the health volunteer possesses.
- 149) The name of the institution at which the health volunteer attained the degree.
- 150) The city of the institution at which the health volunteer attained the degree.
- 151) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 152) The date the degree was conferred.
- 153) The type of credential awarded by the National Association of Social Workers. See Appendix 6 for a list of credentials.
- 154) The expiration date of the credential awarded by the National Association of Social Workers.
- 155) The type of certification awarded by the National Association of Social Workers. See Appendix 6 for a list of certifications.
- 156) The expiration date of the certification awarded by the National Association of Social Workers.
- 157) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 158) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 159) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 160) The type of setting the health volunteer actively practices in (Hospital | Private or Group Practice | Clinic | Public Health).
- 161) The date which the health volunteer started practicing active clinical work at the non-hospital organization.
- 162) Question: "Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participating in federal or state health care programs?"

## 12.10 Occupation: Psychologist

Psychologists collect, interpret, and apply scientific data related to human behavior and mental processes. They may study the way people think, feel, or behave in order to understand, explain, or help them change their actions or manage stress. Psychologists specialize in a wide variety of areas, such as clinical, social, counseling, industrial, school, educational, behavioral, experimental, rehabilitation/vocational, forensic, and neuro-psychology.

<b>Psychologist</b>		
	<b>Category</b>	<b>Data Element</b>
163	State License	Licensee Name
164		License Number
165		State
166		Expiration Date
167		Good Standing Question
168		Adverse Actions Question
169	Degree	Degree Type
170		Specialization
171		Institution Name
172		Institution City
173		Institution State
174		Conferred Date
175	ABPP Certification	Specialties
176		Issue Date
177		Expiration Date
178	Hospital Privilege	Hospital Name
179		Hospital City
180		Hospital State
181	Active Clinical Practice (non-hospital)	Organization Name
182		Organization City
183		Organization State
184		Start Date
185	Previous Clinical Experience	Organization Name
186		Organization City
187		Organization State
188		Clinical Setting
189		Start Date
190		End Date
191	Inspector General Status	Fraud Question

163) The health volunteer's exact name as it appears on the license.

164) The unique license number.

165) The State which issued the license. See Appendix 10 for a list of States and territories.

166) The expiration date of the license.

167) Question: "Is your license in good standing?"

168) Question: "Are there any adverse actions or restrictions associated with your license?"

169) The type of degree the health volunteer possesses (Ph.D. | Psy.D. | Ed.D.).

170) The area of specialization pertaining to the degree attained (Clinical | Counseling | School | and Industrial/Organizational)

171) The name of the institution at which the health volunteer attained the degree.

172) The city of the institution at which the health volunteer attained the degree.

- 173) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 174) The date the degree was conferred.
- 175) The health volunteer's American Boards of Professional Psychology specialization. See Appendix 5 for a list of specialties.
- 176) The date which the health volunteer was awarded the American Boards of Professional Psychology certification.
- 177) The date which the health volunteer's American Boards of Professional Psychology certification expires.
- 178) The name of the hospital where the health volunteer has been granted active hospital privileges.
- 179) The city in which the hospital, where the health volunteer has been granted active hospital privileges, is located.
- 180) The State in which the hospital, where the health volunteer has been granted active hospital privileges, is located. See Appendix 10 for a list of States and territories.
- 181) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 182) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 183) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 184) The date which the health volunteer started practicing active clinical work at the non-hospital organization.
- 185) The name of the organization at which the health volunteer had previously performed clinical work.
- 186) The city in which the organization, where the health volunteer had previously performed clinical work, is located.
- 187) The State in which the organization, at which the health volunteer had previously performed clinical work, is located. See Appendix 10 for a list of States and territories.
- 188) The type of setting the health volunteer actively practices in (Hospital | Private or Group Practice | Clinic | Public Health).
- 189) The date which the health volunteer started performing clinical work at this organization.
- 190) The date which the health volunteer finished performing clinical work at this organization.
- 191) Question: "Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participating in federal or state health care programs?"

### **12.11 Occupation: Mental Health Counselor**

Mental health counselors counsel with an emphasis on prevention, and work with individuals and groups to promote optimum mental health. Mental health counselors may help individuals deal with addictions and substance abuse; family, parenting, and marital problems; suicide; stress management; problems with self-esteem; and issues associated with aging, and mental, and emotional health.

<b>Mental Health Counselor</b>		
	<b>Category</b>	<b>Data Element</b>
192	State License	Licensee Name
193		License Number
194		State
195		Expiration Date
196		Good Standing Question
197		Adverse Actions Question
198	Degree	Degree Type
199		Educational Institution Name
200		Educational Institution City
201		Educational Institution State
202		Conferred Date
203	Active Clinical Practice	Organization Name
204		Organization City
205		Organization State
206		Clinical Setting
207		Start Date
208	Previous Clinical Experience	Supervisor Name
209		Organization Name
210		Organization City
211		Organization State
212		Clinical Setting

- 192) The health volunteer's exact name as it appears on the license.
- 193) The unique license number.
- 194) The State which issued the license. See Appendix 10 for a list of States and territories.
- 195) The expiration date of the license.
- 196) Question: "Is your license in good standing?"
- 197) Question: "Are there any adverse actions or restrictions associated with your license?"
- 198) The type of degree the health volunteer possesses.
- 199) The name of the institution at which the health volunteer attained the degree.
- 200) The city of the institution at which the health volunteer attained the degree.
- 201) The State of the institution at which the health volunteer attained the degree. See Appendix 10 for a list of States and territories.
- 202) The date the degree was conferred.
- 203) The name of the non-hospital organization where the health volunteer practices active clinical work.
- 204) The city of the non-hospital organization where the health volunteer practices active clinical work.
- 205) The State of the non-hospital organization where the health volunteer practices active clinical work. See Appendix 10 for a list of States and territories.
- 206) The type of setting the health volunteer actively practices in (Hospital | Private or Group Practice | Clinic | Public Health).
- 207) The date which the health volunteer started practicing active clinical work at the non-hospital organization.

- 208) The name of the health volunteer's supervisor during clinical experience.
- 209) The name of the organization at which the health volunteer had previously performed clinical work.
- 210) The city in which the organization, where the health volunteer had previously performed clinical work, is located.
- 211) The State in which the organization, at which the health volunteer had previously performed clinical work, is located. See Appendix 10 for a list of States and territories.
- 212) The type of setting the health volunteer gained clinical experience (Hospital | Private or Group Practice | Clinic | Public Health).

## 12.12 Determining Supplemental Information Needs

In addition to collecting information necessary to perform the required System function, as described in the System Design section, an ESAR-VHP System may integrate a wider information set to allow for enhanced operations and functionality. For the benefit of System Administrators, definitions are provided for disaster training information, contact information, and emergency contact information (all optional information).

### *Disaster Training Information*

Disaster training information is detailed information regarding disaster training a health volunteer has undergone. If training information is collected by a State ESAR-VHP System, all data elements in the disaster training table are required.

Disaster Training Information		
	Category	Data Element
213	Training Information	Training Completed
214		Training Title
215		Institution Name
216		Completed Date
217		Expiration Date

- 213) Whether a health volunteer has completed a disaster training course.
- 214) The title of the given training class.
- 215) The institution where the health volunteer completed this training.
- 216) The date which this training was completed.
- 217) The date which this training expires.

### *Contact Information*

Contact information includes phone, fax, and pager numbers by which a health volunteer can be contacted in the event of a disaster. Both primary and alternate contact information will be collected.

Contact Information		
	Category	Data Element
218	Contact Information	Device Type
219		Number

- 218) The device type of the given number. (Home Phone | Work Phone | Mobile Phone | Fax | Alpha/Text Pager | Voice Pager).
- 219) The number to contact the health volunteer at during a declared emergency (includes optional extension).

*Emergency Contact Information*

Emergency contact information includes individuals and contact numbers to notify on the health volunteer's behalf in case of an emergency.

<b>Emergency Contact Information</b>		
	<b>Category</b>	<b>Data Element</b>
220	Emergency Contact Information	Emergency Contact Name
221		Relationship
222		Emergency Contact Number 1
223		Emergency Contact Number 2

- 220) The name of the health volunteer's emergency contact.
- 221) The emergency contact's relationship to the health volunteer (Spouse | Co-worker | Relative | Friend | Other).
- 222) The primary number to reach the emergency contact at (includes optional extension).
- 223) The secondary number to reach the emergency contact at (includes optional extension).



## Appendix 1: State and Institutional Approaches to Training

### A1.1 Overview

There is no substitute for disaster training when preparing health volunteers. The information contained in this section describes approaches at the State and institutional levels illustrating various approaches to training health volunteers and demonstrating how information about training activities may be incorporated into the ESAR-VHP System.

There is agreement by NBHPP key authorities that a minimum level of training for all health volunteers is desirable. State, public health, and hospital authorities presently do not have a standard view or approach to curriculum requirements for health volunteer training. At the volunteer program level, such as the Red Cross and Medical Reserve Corps, and at the level of some States, training programs do exist and, in some cases, are well developed. However, there is not a single generally accepted training curriculum on a national or even statewide basis to prepare health volunteers.

Assessment of the volunteer's learning should be done by, at least, testing of the knowledge gained in a course through a written examination. Ideally, training programs would evaluate the trainee's skills through hands-on exercises, for example.

### A1.2 Wisconsin's Approach to Health Volunteer Training Issues



#### Wisconsin's Approach to Training

##### *Pediatric Trauma Preparedness Modules*

Wisconsin released 12 pediatric trauma preparedness modules for all to access via the web. Covering both clinical and social/emotional topics, these free educational modules include streaming video, interactive PowerPoint presentations and online assessment. The modules were prepared by nationally recognized content experts and include extensive resources for practical application. While these modules are targeted to primary care clinicians, nurses, EMS, first responders, teachers, social workers, childcare providers, and others caring for children, they are also beneficial to the general public concerned about the impact of any trauma, ranging from a community tragedy to a national security bioterrorism threat.

The competency-based modules were specifically designed to be useful to a multi-disciplinary audience. Each module begins with a set of objectives and ends with an opportunity for users to test their knowledge. In addition to the post-test, an evaluation allows users, after the completion of the modules, to rate their confidence level in terms of their ability to address the problems of children who present with the specific trauma, addressed by each module.

The Trauma Preparedness modules were developed through funds from the National Bioterrorism Hospital Preparedness Program of the Health Resources and Services Administration (HRSA), awarded to Children's Health Alliance of Wisconsin, Children's

Hospital of Wisconsin Poison Control Center and Children's Health Education Center by the Wisconsin Division of Public Health. These partners are implementing communication strategies to ensure wide spread promotion of the modules through professional associations, conferences, list serves, State and local government agencies, child care agencies, and other available resources.

You can visit <http://www.chawisconsin.org/traumapreparedness.htm> to access the pediatric trauma preparedness modules, which include the following topics:

- Module 1: Category A Bioterrorism
- Module 2: Respiratory Resuscitation & Isolation
- Module 3: Emergency Dosing
- Module 4: Botulism Toxicity
- Module 5: Bacterial Food Borne Illness
- Module 6: Choking Agents
- Module 7: Cyanide Toxicity
- Module 8: Cholinergic Syndrome
- Module 9: Communicating Unseen Threats
- Module 10: Returning to "New" Normal
- Module 11: Schools as Community Partners
- Module 12: Children & Stress

Contributors are listed in Appendix 2.

## A1.2 Texas's Approach to Health Volunteer Training Issues



### Texas's Approach to Volunteer Training

Texas is developing a system to record the courses completed by health volunteers. The Texas Ready Nurse program allows nurses to self-register in a database on the Texas Nurses Association web site. Once required training and competencies are identified for the health volunteer, the training information will be noted on the health volunteer's profile within the Ready Nurse database, which will be a component of the Statewide ESAR-VHP System.

Regionally, the Core Disaster Life Support (CDLS) program and the Basic Disaster Life Support (BDLS) program are offered and funded through HRSA's Bioterrorism Curriculum Development Program. Within Texas, hospitals are organized by region and training requirements are determined on a regional basis, and the State has not yet required training nor identified a State-level set of approved courses. The Texas legislature, however, has mandated 2 hours of disaster preparedness education for nurses for re-licensure.

Texas will examine how to integrate all State approved training programs into the State's developing ESAR-VHP model. In Texas, in addition to regional training initiatives, there are

a number of regional efforts already underway related to the ESAR-VHP program. For example, the El Paso region has a process of registering and assembling credentials for physicians. Once a physician completes the registration process, the health volunteer is issued a sticker that is applied to the back of his or her driver's license. The San Antonio region is developing a "smart card" for physicians and nurses that will carry information about their background and training. In Dallas/Fort Worth, health volunteer information will also be recorded on a card-type system. Along with training, each of these complementary and other existing activities will need to be incorporated throughout Texas into a integrated ESAR-VHP System.

Contributors are listed in Appendix 2.

### A1.3 Connecticut's Approach to Health Volunteer Training Issues



#### Connecticut's Approach to Training

The focus of Connecticut's Emergency Credentialing Program, that serves as the State's ESAR-VHP, is to support the personnel surge capacity needs for the State's acute care hospitals. The education and training requirements for these volunteers specifically address the needs of the hospitals, as well as accreditation standards related to emergency response.

Actively practicing healthcare professionals who are interested in registering on ESAR-VHP do not have large blocks of time to devote for disaster training. Therefore, it is important that any required training be minimal. Connecticut has implemented Emergency Management 102 (EM 102), a competency-based training program (awareness level) emergency preparedness course, as the only required pre-event training for its hospital disaster volunteers. EM 102, addresses the impact on hospitals of emergencies and disasters, identifies the roles and responsibilities of healthcare delivery workers, and discusses mental health needs and basic information on personal and family emergency preparedness. EM 102 prepares healthcare delivery workers to understand their role in providing continuous care for existing and additional patients in the event of an emergency. By requiring EM 102 of all Connecticut's acute care hospitals, healthcare delivery workers have the same level of basic emergency preparedness competency. Connecticut volunteers may access the training at their employing facility or via an on-line learning management system. The EM 102 course has been implemented in other States and countries and is available to any interested organization at no charge.

Under all circumstances, the safety of the volunteers and the healthcare facility is of paramount importance and no volunteer should be deployed within the facility without being minimally prepared through appropriate "just-in-time" education and training. When the volunteer is deployed to a hospital, he or she will first be positively identified and then assigned to an appropriate supervisor or professional mentor. Volunteers receive "just-in-time" training that is:

- *Hospital-specific:* facility disaster code, location of fire pull stations, extinguisher, important phone numbers.
- *Discipline-specific:* physician, nurse, physician assistant, respiratory therapy, diagnostic imaging.
- *Disaster-specific:* appropriate safety precautions, crisis communication, clinical and operating protocols, applicable technology (IT, equipment).

Contributors are listed in Appendix 2.

#### A1.4 Georgia's Approach to Health Volunteer Training Issues



##### Georgia's Approach to Training

Georgia's hospitals are in 19 public health districts. A pilot project, funded by HRSA and MMRS, is underway within one district to utilize the hospitals within that district as the organizations to verify and update the credentials of volunteer health professionals (physicians, nurses). When the hospital records are updated, the district records are automatically updated as well. The information on volunteers that is stored in the database is the minimum needed to grant privileges at other institutions. The volunteer is issued a photo ID with a unique bar code that can be scanned. This provides information about the volunteer that is stored in his or her hospital's database.

Information about the volunteer's training history is entered into the database by the volunteer's hospital or district. When this pilot program goes statewide, the State office will enter training information.

The State of Georgia is providing a number of training opportunities for volunteers. HRSA-funding is allowing the Core Disaster Life Support (CDLS) – Decontamination, a 16 hour program to be offered across the State. The one-day Basic Disaster Life Support program is being provided 10 times across the State, to accommodate about 1500 participants during 2005. A Healthcare Disaster Awareness and Preparedness toolkit (video and information packet) is being made available to all hospital-based health workers.

Contributors are listed in Appendix 2.

### **A1.5 Training Program Development by The International Nursing Coalition for Mass Casualty Education (INCMCE)**



#### **INCMCE Training Program Development**

*An Online Curriculum from the International Nursing Coalition for Mass Casualty Education*

The International Nursing Coalition for Mass Casualty Education (INCMCE) is coordinated by the Vanderbilt University School of Nursing and was founded in 2001 to assure a competent nurse workforce to respond to mass casualty incidents. The INCMCE consists of organizational representatives from schools of nursing, nursing accrediting bodies, nursing specialty organizations and governmental agencies interested in promoting mass casualty education for nurses.

One of the early functions of INCMCE was to agree on a list of competencies for all nurses so that a standardized curriculum could be created (see <http://www.incmce.org> for the competencies). INCMCE has received two federal grants to develop and deliver an online curriculum designed to allow learners to achieve the INCMCE competencies. Six online modules are planned based on the “How People Learn” framework that was developed after a review of the educational literature for the National Research Council. When completed, the modules will be available without charge via the INCMCE web site. The first two modules also have been distributed on CD-ROM and have been pilot tested in the US by a variety of educators with a nursing audience. Formal data collection through the web began March 1, 2005 after changes from the pilot test phase were incorporated.

Contributors are listed in Appendix 2.

### **A1.6 Training Program Development By The University of Pittsburgh Medical Center (UPMC) Health System**

#### **University of Pittsburgh Medical Center (UPMC) Health System**

##### *Disaster Preparedness Training Tools for Hospital Emergency Department Staff*

Researchers involved with a project spearheaded by the UPMC Health System are creating a “toolbox” for use in disaster preparedness training. This project was made possible by funding from the Agency for Healthcare Research and Quality. The training tool addresses role-specific educational competencies for four hospital groups (physicians, nurses, technicians, and administrators) who work in emergency department settings. The competency-based training uniquely tailors disaster preparedness education by providing over two dozen resource tools that are available, free of charge, over the web, allowing the training program to be

completed at the convenience of staff. Learning begins with a review of core knowledge and continues with a series of topics related to disaster response and recovery for the four health professions. To further motivate learners, low-cost continuing medical education credits or CEUs are available. This competency based training will be used by Pennsylvania's State Learning Management System (LMS), which currently has registered over 13,000 preparedness related health professionals.

Contributors are listed in Appendix 2.

## Appendix 2: Contributors to State and Institutional Example Approaches to Key Issues

### State of Connecticut

Approaches cited: Training, Credentialing, Health Volunteer Recruitment and Advocacy

Mary Grace Duley, MA, RN, CEN  
Hospital Preparedness Coordinator  
Office of Public Health Preparedness  
Connecticut Department of Public Health

Elaine Forte, BS, MT (ASCP)  
Program Development Manager  
Yale New Haven Health System

Theresa Zinck Lederer, MPH, CPMSM,  
CPCS  
Director, Physician Services  
Yale-New Haven Hospital

### State of Georgia

Approach cited: Training

Dennis L. Jones, RN,BSN  
State Hospital Community Preparedness Coordinator  
Georgia Division of Public Health

### State of Minnesota

Approach cited: Credentialing

Pat Tommet, RN, PhD, CNP  
Hospital Preparedness Unit Supervisor  
Minnesota Department of Health  
Office of Emergency Preparedness

Megan Thompson  
Hospital Preparedness Specialist  
Minnesota Department of Health  
Office of Emergency Preparedness

Lisa Pogoff  
Workforce Registry Planner  
Minnesota Department of Health  
Office of Emergency Preparedness

### State of Texas

Approaches cited: Training, Credentialing, Health Volunteer Recruitment and Advocacy

Ron Hilliard, RN, BSN  
Manager, Hospital Preparedness Program  
Community Preparedness Section  
Texas Department of State Health Services

**State of Ohio**

Approaches cited: Initial System Planning

Ohio Volunteer Medical Response Corps  
Committee  
Ohio Department of Health, Chair  
American Red Cross  
Association of Ohio Health Commissioners  
Infectious Disease Society of Ohio  
Ohio Chapter, American College of  
Emergency Physicians  
Ohio Community Service Council  
Ohio Dental Association  
Ohio Department of Mental Health  
Ohio Emergency Management Agency  
Ohio Emergency Medical Services  
Ohio Emergency Nurses Association

Ohio Hospital Association  
Ohio Nurses Association  
Ohio Osteopathic Association  
Ohio Pharmacists Association  
Ohio Psychiatric Association  
Ohio State Medical Association  
Ohio State Dental Board  
Ohio State Medical Board  
Ohio funded Medical Reserve Corps:  
Defiance County General Health District  
Licking County Health Department  
Lucas County Regional Health District  
Montgomery County, Combined General  
Health District

**State of Wisconsin**Approaches cited: Training, Credentialing, Health Volunteer Recruitment and Advocacy,  
Security and Privacy

Dennis J. Tomczyk  
Director, Hospital Bioterrorism  
Preparedness  
Wisconsin Division of Public Health  
  
Billee Bayou  
Bioterrorism Preparedness Program  
Wisconsin Division of Public Health

Kate Conklin, CPMSM, CPCS  
Immediate Past President, Wisconsin  
Association Medical Staff Services  
Great Lakes Region Representative, National  
Association Medical Staff Services  
Manager, Credentials Verification/Physician  
Relations Department, St. Vincent Hospital

**The International Nursing Coalition for Mass Casualty Education (INCMCE)**

Approach cited: Training

Betsy Weiner, PhD, RN, BC, FAAN  
Associate Director of the INCMCE  
Senior Associate Dean for Educational Informatics  
Associate Director, International Nursing  
Coalition for Mass Casualty Education

**University of Pittsburgh Medical Center  
(UPMC) Health System**  
Approach cited: Training

Dr. Lucy Savitz, PhD, MBA  
Project Director  
RTI International



## Appendix 3: American Board of Medical Specialties and Subspecialties

<b>AMERICAN BOARD of</b>	<b>GENERAL CERTIFICATE(S)</b>	<b>SUBSPECIALTY CERTIFICATE(S)</b>
Allergy & Immunology	Allergy & Immunology	Clinical & Laboratory Immunology
Anesthesiology	Anesthesiology	Critical Care Medicine Pain Medicine
Colon & Rectal Surgery	Colon & Rectal Surgery	
Dermatology	Dermatology	Clinical & Laboratory Dermatological Immunology Dermatopathology Pediatric Dermatology
Emergency Medicine	Emergency Medicine	Medical Toxicology Pediatric Emergency Medicine Sports Medicine Undersea & Hyperbaric Medicine
Family Medicine	Family Practice	Adolescent Medicine Geriatric Medicine Sports Medicine
Internal Medicine	Internal Medicine	Adolescent Medicine Cardiovascular Disease Clinical Cardiac Electrophysiology Clinical & Laboratory Immunology Critical Care Medicine Endocrinology, Diabetes & Metabolism Gastroenterology Geriatric Medicine Hematology Infectious Disease Interventional Cardiology Medical Oncology Nephrology Pulmonary Disease Rheumatology Sleep Medicine Sports Medicine Transplant Hepatology
Medical Genetics	Clinical Biochemical Genetics  Clinical Cytogenetics Clinical Genetics (M.D.) Clinical Molecular Genetics  Ph.D. Medical Genetics	Molecular Genetic Pathology

<b>AMERICAN BOARD of</b>	<b>GENERAL CERTIFICATE(S)</b>	<b>SUBSPECIALTY CERTIFICATE(S)</b>
Neurological Surgery	Neurological Surgery	
Nuclear Medicine	Nuclear Medicine	
Obstetrics & Gynecology	Obstetrics & Gynecology	Critical Care Medicine Gynecologic Oncology Maternal & Fetal Medicine Reproductive Endocrinology/Infertility
		Gynecologic Oncology
Ophthalmology	Ophthalmology	
Orthopaedic Surgery	Orthopaedic Surgery	Surgery of the Hand Orthopaedic Sports Medicine
Otolaryngology	Otolaryngology	Neurotology Plastic Surgery Within the Head and Neck Pediatric Otolaryngology
Pathology	Anatomic Pathology & Clinical Pathology  Anatomic Pathology Clinical Pathology	Blood Banking/Transfusion Medicine Chemical Pathology Cytopathology Dermatopathology Forensic Pathology Hematology Medical Microbiology Molecular Genetic Pathology Neuropathology Pediatric Pathology
Pediatrics	Pediatrics	Adolescent Medicine Clinical & Laboratory Immunology Developmental-Behavioral Pediatrics Medical Toxicology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Pulmonology Pediatric Rheumatology Pediatric Transplant Hepatology Sleep Medicine Sports Medicine

<b>AMERICAN BOARD of</b>	<b>GENERAL CERTIFICATE(S)</b>	<b>SUBSPECIALTY CERTIFICATE(S)</b>
Physical Medicine & Rehabilitation	Physical Medicine & Rehabilitation	Pain Medicine Spinal Cord Injury Medicine Pediatric Rehabilitation Medicine
Plastic Surgery	Plastic Surgery	Plastic Surgery Within the Head and Neck Surgery of the Hand
Preventive Medicine	Aerospace Medicine Occupational Medicine  Public Health & General Preventive Medicine	Medical Toxicology Undersea & Hyperbaric Medicine
Psychiatry & Neurology	Psychiatry Neurology  Neurology with Special Qualifications in Child Neurology	Addiction Psychiatry Child & Adolescent Psychiatry Clinical Neurophysiology Forensic Psychiatry Geriatric Psychiatry Neurodevelopmental Disabilities Pain Medicine Psychosomatic Medicine Sleep Medicine Vascular Neurology
Radiology	Diagnostic Radiology Radiation Oncology Radiological Physics	Neuroradiology Nuclear Radiology Pediatric Radiology Vascular & Interventional Radiology
Surgery	Surgery Vascular Surgery	Pediatric Surgery Surgery of the Hand Surgical Critical Care
Thoracic Surgery	Thoracic Surgery	
Urology	Urology	

Source: American Board of Medical Specialties: <http://www.abms.org/approved.asp>



## Appendix 4: American Osteopathic Association Specialty Boards

Certification is recognition by one of the 18 AOA Approved Specialty Boards that a D.O. has achieved expertise in a medical specialty or subspecialty.\*

Doctors of osteopathic medicine can become AOA certified in the following areas:

- Anesthesiology
- Dermatology
- Emergency Medicine
- Family Practice
- Internal Medicine
- Neurology and Psychiatry
- Neuromuskuloskeletal Medicine
- Nuclear Medicine
- Obstetrics and Gynecology
- Ophthalmology and Otolaryngology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Preventive Medicine
- Proctology
- Radiology
- Surgery

All osteopathic boards can also certify osteopathic physicians.

A table of subspecialties of the AOA Specialty Boards will be included in subsequent versions of the Guidelines.

Sources: [http://www.osteopathic.org/index.cfm?PageID=ado\\_cert](http://www.osteopathic.org/index.cfm?PageID=ado_cert)  
[http://do-online.osteotech.org/index.cfm?PageID=crt\\_memboards](http://do-online.osteotech.org/index.cfm?PageID=crt_memboards)



## **Appendix 5: American Board of Professional Psychology Specialty Boards**

- The American Board of Cognitive and Behavioral Psychology
- The American Board of Clinical Psychology
- The American Board of Clinical Child and Adolescent Psychology
- The American Board of Clinical Health Psychology
- The American Board of Clinical Neuropsychology
- The American Board of Counseling Psychology
- The American Board of Family Psychology
- The American Board of Forensic Psychology
- The American Board of Group Psychology
- The American Board of Psychoanalysis in Psychology
- The American Board of Rehabilitative Psychology
- The American Board of School Psychology
- The American Board of Organizational and Business Consulting Psychology

Source: [http://www.abpp.org/brochures/general\\_brochure.htm](http://www.abpp.org/brochures/general_brochure.htm)



## **Appendix 6: National Association of Social Workers Specialty Certifications**

- Certified Advanced Children, Youth, and Family Social Worker (C-ACYFSW)
- Certified Children, Youth, and Family Social Worker (C-CYFSW)
- Certified Social Worker in Health Care (C-SWHC)
- Certified Clinical Alcohol, Tobacco, and Other Drugs Social Worker (C-CATODSW)
- Certified Advanced Social Worker Case Manager (C-ASWCM)
- Certified Social Worker Case Manager (C-SWCM)
- Certified School Social Work Specialist (C-SSWS)

Source: <http://www.socialworkers.org/credentials/default.asp>



## Appendix 7: American Board of Nursing Specialties Certifications

There are at least 42 certifying organizations and 93 specialties.

- a. American Board of Perianesthesia Nursing Certification (ABPANC, Inc)
  - i. Certified Post Anesthesia Nurse (CPAN)
  - ii. Certified Ambulatory Perianesthesia Nurse (CAPA)
- b. American Board for Occupational Health Nurses (ABOHN, Inc)
  - i. COHN
  - ii. COHN-S
  - iii. COHN-S/CM
- c. American Board of Neuroscience Nursing (ABNN)
  - i. CNRN
- d. American Legal Nurse Consultant Certification Board (ALNCCB)
  - i. LNCC
- e. American Nurses Credentialing Center
  - i. Advance Practitioner Certifications
    - 1. Acute Care Nurse Practitioner
    - 2. Adult Nurse Practitioner
    - 3. Family Nurse Practitioner
    - 4. Gerontological Nurse Practitioner
    - 5. Pediatric Nurse Practitioner
    - 6. Adult Psychiatric and Mental Health Nurse Practitioner\*
    - 7. Family Psychiatric and Mental Health Nurse Practitioner\*
    - 8. Clinical Specialist in Gerontological Nursing
    - 9. Clinical Specialist in Medical-Surgical Nursing
    - 10. Clinical Specialist in Pediatric Nursing\*
    - 11. Clinical Specialist in Adult Psychiatric and Mental Health Nursing
    - 12. Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing
    - 13. Clinical Specialist in Community Health Nursing
    - 14. Clinical Specialist in Home Health Nursing
    - 15. Advanced Diabetes Management--Clinical Specialist
    - 16. Advanced Diabetes Management--Nurse Practitioner
    - 17. Advanced Diabetes Management--Registered Dietitian
    - 18. Advanced Diabetes Management--Registered Pharmacist
    - 19. Nursing Administration, Advanced
  - ii. Baccalaureate-Level Certifications
    - 1. Cardiac/Vascular Nurse
    - 2. College Health Nurse
    - 3. Community Health Nurse
    - 4. Gerontological Nurse
    - 5. Home Health Nurse
    - 6. Informatics Nurse: Baccalaureate degree in nursing
    - 7. Informatics Nurse: Baccalaureate degree in other relevant field of study

- 8. Medical-Surgical Nurse
- 9. Nursing Professional Development
- 10. Pediatric Nurse
- 11. Perinatal Nurse
- 12. Psychiatric and Mental Health Nurse
- 13. Nursing Administration
- iii. Associate Degree/Diploma Level Certifications
  - 1. Cardiac/Vascular Nurse
  - 2. Gerontological Nurse
  - 3. Medical-Surgical Nurse
  - 4. Pediatric Nurse
  - 5. Perinatal Nurse
  - 6. Psychiatric and Mental Health Nurse
- iv. Other Specialty Certifications
  - 1. Ambulatory Care Nursing
  - 2. Nursing Case Management
  - 3. Pain Management
- f. Board of Certification for Emergency Nursing (BCEN)
  - i. CEN
- g. Competency & Credentialing Institute (CCI – formerly Certification Board Perioperative Nursing (CBPN))
  - i. CNOR
  - ii. CRNFA
- h. Council on Certification of Nurse Anesthetists (CCNA)
  - i. CRNA
- i. National Board of Certification for Hospice and Palliative Nurses (NBCHPN)
  - i. CHPN
- j. Nephrology Nursing Certification Commission (NNCC)
  - i. CNN
- k. Oncology Nursing Certification Corporation (ONCC)
  - i. OCN
  - ii. CPON
  - iii. AOCN
- l. Rehabilitation Nursing Certification Board (RNCB)
  - i. CRRN
  - ii. CRRN-A

Sources: [http://www.nursingcertification.org/exam\\_programs.htm](http://www.nursingcertification.org/exam_programs.htm)  
<http://nursingworld.org/ancc/certification/certs.html>

## Appendix 8: ESAR-VHP Guidelines Glossary of Terms

**Active Clinical Privileges:** Privileges to work in a hospital setting.

**Advance Practice Nurse (APN):** A Registered Nurse who has completed additional coursework and clinical practice requirements leading to recognition as a Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), or Certified Nurse Midwife (CNM).

**Agency:** A division of government with a specific function offering a particular kind of assistance. In the Incident Command System (ICS), agencies are defined either as jurisdictional (having statutory responsibility for incident management) or as assisting or cooperating (providing resources or other assistance) with those organizations requesting aid.

**Agency Representative:** A person assigned by a primary, assisting, or cooperating Federal, State, local, or tribal government agency or private entity that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency.

**All-Hazard:** Covering all possible hazards whether natural, accidental, negligent, or intentional.

**All-Hazards Preparedness:** Preparedness for domestic terrorist attacks, major disasters, and other emergencies.

**Authentication:** Pertaining to the process by which information on the health volunteer is checked against a credible source to establish information legitimacy.

**Authority:** The constitutional, statutory, regulatory, or other legal powers of State (and local) governments to control functions of the State's ESAR-VHP Systems.

**Bioterrorism (BT):** The use of a biological agent in a terrorist incident; the intentional use of microorganism or toxins derived from living organisms to produce death or disease in humans, animals, or plants.

**Certification:** A formal document that recognizes that an individual has successfully completed the education, training, and experience needed to specialize in a certain area.

**Certify:** To officially authorize, recognize, or document information on an individual.

**Chain of Command:** A series of command, control, executive, or management positions in hierarchical order of authority.

**Check-In:** The process through which resources first report to an incident. Check-in locations include the incident command post, Resources Unit, incident base, camps, staging areas, or directly on the site.

**Command:** The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.

**Communicable Disease:** An illness due to a specific infectious agent or toxic products that arise through transmission of that agent or its products from an infected person or animal to a susceptible host. (Contrast with infectious disease).

**Communications:** The system by which a message is communicated.

**Competency:** A broad statement detailing a complex, but observable, set of behaviors including components of knowledge, skill, and attitude.

**Coordinate:** To advance, systematically, an analysis and exchange of information among principals who have or may have a need to know certain information to carry out specific incident management responsibilities.

**Counterterrorism:** The full range of activities directed against terrorism, including preventive, deterrent, response and crisis management efforts.

**Credential:** A health volunteer's qualifications. Credentials are used with an ESAR-VHP System to determine a health volunteer's emergency credentialing level. According to JCAHO, credentials are the documented evidence of licensure, education, training experience or other qualifications.<sup>9</sup>

**Credentialing:** The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in one or more fields. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used.

**Data Definition:** The description of the data attributes that identify an information element.

**Data Element:** A stored element within a database that is associated with a health volunteer record.

**Database:** An organized collection of information stored in electronic form.

**Degree:** Academic title conferred by universities and colleges as an indication of the completion of a course of study

**Designated Equivalent Source:** Selected agencies that have been determined to maintain a specific item or items of credential information that is identical to the information at the primary source.

**Disaster, Major (Federal):** “Major disaster” means any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under this [Stafford] Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. (From: Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended by Public Law 106-390, October 30, 2000, Sec. 102).

**Dispatch:** The ordered movement of a resource or resources to an assigned operational mission or an administrative move from one location to another.

**Doctor of Osteopathy (DO):** A physician who is a graduate from an accredited school of osteopathic medicine.

**Drills:** Small-scale, internally conducted, activities aimed at providing a more “hands-on” teaching environment to familiarize staff with actual procedures necessary for emergency operations. They may be stopped and restarted in order to clarify a point, provide instruction, allow for observations from the evaluator and evaluatee, or to permit the evaluatee a second chance to perform a procedure or activity. Also see **Exercise**.

**ESAR-VHP System:** Emergency System for Advance Registration of Volunteer Health Professionals. An electronic database of health care personnel who volunteer to provide aid in an emergency. An ESAR-VHP System must provide for (1) registration of health volunteers, (2) designation of emergency credentialing levels, and (3) the emergency verification of the identity, credentials, and qualifications of volunteers.

**Emergency:** Absent a Presidentially-declared emergency, any incident(s), human-caused or natural, that requires responsive action to protect life or property.

**Emergency Credentialing Level:** A designation assigned to a health volunteer registered in an ESAR-VHP System based on possessed and verified credentials, as defined by Emergency Credentialing Standards. The highest emergency credential level is 1 and indicates that the health volunteer possesses all of the minimum required credentials and that the credentials have been appropriately verified.

**Emergency Credentialing Standards:** A taxonomy intended to promote interoperability and integration of medical and health personnel commonly needed in an emergency response. Within the ESAR-VHP program, the application of emergency credentialing standards is a uniform process of classifying a health volunteer into an emergency credentialing level based on verified credentials possessed by the health volunteer.

**Emergency Declaration:** Refers to the State (or local) government’s capacity to declare a general emergency or public health emergency, or state of disaster. Nearly every State has developed a legal structure for declaring an emergency or state of disaster, and many States have

legal procedures for declaring public health emergencies. See the Legal and Regulatory Issues Report, Section 3.1., for more information.

**Emergency, Federal:** Any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States (From: Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended by Public Law 106-390, October 30, 2000, Sec. 102).

**Emergency Management:** A systematic program of activities a government and its partners undertake before, during, and after a disaster to save lives, prevent injury, and to protect property and the natural environment.

**Emergency Management Assistance Compact (EMAC):** An interstate mutual aid agreement that allows States to assist one another in responding to all types of natural and man-made disasters.

**Emergency Operations Centers (EOC):** The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, county, city, tribal), or some combination thereof.

**Emergency Public Information:** Information that is disseminated primarily in anticipation of an emergency or during an emergency. In addition to providing situational information to the public, it also frequently provides directive actions required to be taken by the general public.

**Emergency Response Provider:** Includes Federal, State, local, and tribal emergency public safety, law enforcement, emergency response, emergency medical (including hospital emergency facilities), and related personnel, agencies, and authorities. See Section 2 (6), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135 (2002). Also known as **Emergency Responder**.

**Epidemic:** The occurrence in a community or region of cases of an illness (or outbreak) with a frequency clearly in excess of normal expectancy.

**Exercise:** Large-scale enactment of emergency situations to test the response system and plan. They are usually developed and evaluated by an external agency. An exercise is a test of knowledge and is not to be interrupted except for safety concerns or for a true emergency situation.

**Federal:** Of or pertaining to the Federal Government of the United States of America.

**Firewall:** A network configuration, usually both hardware and software that forms a barrier between networked computers within an organization and those outside the organization.

**First Responder:** Those individuals who in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers.

**Hazard:** A source of potential harm from past, current, or future exposures.

**Health Volunteer:** Medical or healthcare professional who renders aid or performs health services, voluntarily, without pay or remuneration.

**Health Volunteer Advocacy:** The means by which States can spread awareness of the ESAR-VHP System and facilitate the registration and retention of volunteer health professionals in the ESAR-VHP System, including the identification and provision of effective incentives and necessary protective measures for health volunteers.

**Health Volunteer Record:** The complete set of information maintained on the health volunteer by the ESAR-VHP System. Each health volunteer's record must be accessible by the System's authorized administrator and typically contains the health volunteer's registry information, credential information, pre-qualification information.

**Hospital:** A health care organization that has a governing body, an organized medical and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week. For licensing purposes, each State has its own definition of a hospital.

**Hospital Emergency Incident Command System (HEICS):** An emergency management system that employs a logical management structure, defined responsibilities; clear reporting channels and a common nomenclature to help unify hospitals with other emergency responders.

**Incident:** An occurrence or event, natural or human-caused, that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wild land and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

**Incident Command System (ICS):** A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. ICS is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

**Incident Commander (IC):** The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

**Incident Management:** Referring to the totality of activities to be aware of, prevent, prepare for respond to, and recover from incidents. This term is emphasized in the National Response Plan and replaces the terms: Emergency Management, Disaster Management, Crisis Management, and Consequence Management.

**Indemnity:** Protection from, or compensation for, damage, loss, or injury.

**Indeterminate:** Describes a credential that is not verified, and therefore, may or may not be possessed by the health volunteer.

**Information Element:** A stored element within a database that is associated with a health volunteer record.

**In-House:** Assets or expertise specifically owned, possessed, directed, and/or controlled by the responding entity.

**Initial Action:** The actions taken by those responders first to arrive at an incident site.

**Interoperability:** The ability of software and hardware from multiple systems to communicate, share, and coordinate data.

**Interstate:** Between two or more States.

**Intrastate:** Within one State.

**Jurisdiction:** A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, State, or Federal boundary lines) or functional (e.g., law enforcement, public health).

**Level:** A classification of resources that refers to capability. Level 1 is generally considered to be more capable than Level 2, 3, or 4, respectively, because of size; power; capacity; or, in the case of incident management teams, experience and qualifications.

**Licensure:** Affirmation by a duly constituted body, usually a State, that an individual has met certain prescribed qualifications and is therefore recognized under the laws of the State a licensed professional.

**Local Government:** A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under State law), regional or

interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or, in Alaska, a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. See Section 2 (10), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135 (2002).

**Major Disaster:** *See Disaster, Major.*

**Marriage and Family Therapist:** A mental health professional who is trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems. Marriage and family therapists have graduate training (a Master's or Doctoral degree) in marriage and family therapy and at least two years of clinical experience.

**Medical and Public Health Social Workers:** An individual who provides persons, families, or vulnerable populations with the psychosocial support needed to cope with chronic, acute or terminal illnesses, such as Alzheimer's disease, cancer, or AIDS. They also advise family caregivers, counsel patients, and help plan for patients' needs after discharge by arranging for at-home services from Meals on Wheels to oxygen equipment. Some work on interdisciplinary teams that evaluate certain kinds of patients, for example, geriatric or organ transplant patients. Medical and public health social workers may work for hospitals, nursing and personal care facilities, individual and family services agencies, or local governments.

**Medical Doctor (MD):** *See Physician.*

**Mental Health and Substance Abuse Social Workers:** Individuals who assess and treat individuals with mental illness, or substance abuse problems, including abuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They may also help plan for supportive services to ease patients' return to the community. Mental health and substance abuse social workers are likely to work in hospitals, substance abuse treatment centers, individual and family services agencies, or local governments. These social workers may be known as clinical social workers.<sup>10</sup>

**Mental Health Counselors:** An individual who counsels with an emphasis on prevention, and work with individuals and groups to promote optimum mental health. Mental health counselors may help individuals deal with addictions and substance abuse; family, parenting, and marital problems; suicide; stress management; problems with self-esteem; and issues associated with aging, and mental, and emotional health.

**Metrics:** An element of the emergency credentialing standards protocol, metrics are the measurement standards for health volunteers when determining emergency credentialing levels. For the ESAR-VHP program, metrics consist of verified credential elements. The credential elements used as metrics will vary according to occupation.

**Metropolitan Medical Response System (MMRS):** A program intended to increase cities' ability to respond to a terrorist attack by coordinating the efforts of local law enforcement, fire, HAZMAT, EMS, hospital, public health and other personnel.

**Mobilization:** The process and procedures used by all organizations, federal, State, local, and tribal, for activating, assembling, and transporting all resources that have been requested to respond to or support an incident.

**Mutual-Aid Agreement:** Written agreement between agencies and/or jurisdictions that they will assist one another on request, by furnishing personnel, equipment, and/or expertise in a specified manner.

**National:** Of a nationwide character, including the federal, State, local, and tribal aspects of governance and polity.

**National Disaster Medical System (NDMS):** A cooperative, asset-sharing partnership between the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Homeland Security, and the Department of Defense. NDMS provides resources for meeting the continuity of care and mental health services requirements of the Emergency Support Function 8 in the Federal Response Plan.

**National Electronic Disease Surveillance System (NEDSS):** A Centers for Disease Control and Prevention initiative promoting the use of data and information system standards to improve disease surveillance systems at federal, State, and local levels.

**National Incident Management System (NIMS):** The single all-hazards incident management system required by Homeland Security Presidential Directive 5 that will govern the management of the National Response Plan. The National Incident Management System will replace the National Inter-Agency Incident Management System.

**National Practitioner Data Bank (NPDB):** A Federal clearinghouse of information intended to assist in a comprehensive review of credentials by collecting a wide range of adverse actions taken against physicians, dentists and in some cases, other health practitioners. Information that is collected and disseminated to eligible entities includes: medical malpractice payments, Medicare/Medicaid exclusions, and adverse actions against licensure, clinical privileges, and society membership.

Hospitals must query the NPDB before granting privileges to a physician. Other organizations that provide health care services that may query the NPDB include, state licensing boards, boards of medical examiners, certain professional societies and other health care entities such as HMOs, PPOs, group practices, nursing homes, and rehabilitation centers.

**Outbreak:** The occurrence of a number of cases of a disease or condition in any area over a given period of time in excess of the expected number of cases.

**Personnel Accountability:** The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that Incident Command System principles and processes are functional and that personnel are working within established incident management Guidelines.

**Physician:** A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who, by virtue of education, training and demonstrated competence, is fully licensed to practice medicine and may be granted clinical privileges by a health care organization to perform specific diagnostic or therapeutic procedures.

**Physician Assistant (PA):** A medically trained professional who can provide many of the health care services traditionally performed by a physician, such as taking medical histories and doing physical examinations, making diagnoses, prescribing, and administering therapies.

**Preparedness:** Refers to the existence of plans, procedures, policies, training, and equipment necessary at the federal, State, and local levels to maximize the ability to prevent, respond to, and recover from major events. “Readiness” is used interchangeably with “Preparedness.” (HSPD-8).

**Primary Source:** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner.

**Primary Source Verification:** The verification of a credential by the entity that issued the credential to a health care practitioner directly or by means of a Credential Verification Organization (CVO) or by a Joint Commission for the Accreditation of Health Care Organizations designated equivalent source.

**Privacy:** Refers to the rights of health volunteers to control the uses or disclosures of their identifiable information acquired within an ESAR-VHP System.

**Private Sector:** Organizations and entities that are not part of any governmental structure. It includes for-profit and not-for-profit organizations, formal and informal structures, commerce and industry, and private voluntary organizations (PVO).

**Privileges:** Specific scope and content of patient care services authorized by a health care organization to health care practitioner

**Privileging:** The authorization granted by the health care entity for a qualified health professional to provide patient care, treatment, and services with or without supervision. Privileging is performed on a case-by-case basis and the responsibility of assigning privileges resides with the entity that receives volunteers in response to an emergency.

**Psychologists:** Individuals collect, interpret, and apply scientific data related to human behavior and mental processes. They may study the way people think, feel, or behave in order to understand, explain, or help them change their actions or manage stress. Psychologists specialize in a wide variety of areas such as clinical, social, counseling, industrial, school, educational, behavioral, experimental, rehabilitation/vocational, forensic, and neuro-psychology.

**Public Health:** Organized efforts of society to protect, promote, and restore people's health. It is the combination of science, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with variations in technology and social values but the goals remain the same: to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the population. Public health is thus a social institution, a discipline, and a practice.

**Public Health Emergency:** Occurrence or imminent threat of exposure to an extremely dangerous condition or a highly infectious or toxic agent, including a communicable disease, that poses in imminent threat of substantial harm to the population, or any portion thereof. In general, a public health emergency is one that requires a population-based approach. Examples of public health emergencies may include a natural outbreak of an infectious disease, i.e., influenza, Hantavirus, meningitis, salmonella, etc., intentionally caused biological threats such as smallpox, anthrax, and some accidents involving hazardous materials that threaten the health of the population. Public health emergencies can also be or evolve into medical emergencies. Likewise, medical emergencies can develop to an extent that they affect the population's health, and by definition, become public health emergencies. Response to public health emergencies will be led by the Department of Health with assistance by local and State emergency management.

**Public Health Information Network (PHIN):** A framework providing the basis for information technology projects for CDC-funded programs including NEDSS, HAN, and others.

**Public Health Professionals:** Persons educated in public health or a related discipline who are employed to improve the health of populations. These professionals perform three core functions, assessment, policy development, and assurance, as they relate to the prevention and control of disease and disability, and the promotion of physical and mental health of populations on an international, national, State, or municipal level.

**Recovery:** The development, coordination, and execution of service and site restoration plans; the reconstitution of government operations and services; individual, private sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents.

**Recruitment:** The identification and subsequent registration of health volunteer health professionals in a State-based ESAR-VHP registry. Thus, recruited health volunteers are distinguished from "spontaneous" volunteers, i.e. unregistered and uncoordinated health care professionals who may respond to an emergency or disaster situation and volunteer health services.

**Registered Nurse (RN):** An individual who has passed a State registration examination and has been licensed to practice as a registered nurse. The registration license is intended to ensure minimum levels of competence and thus protect the public, not to indicate the educational background of a nurse.

**Response:** Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property, and meet basic human needs as well as executing the plan and resources created to preserve life, protect property and provide services.

**Risk:** A measure of the harm to human health that results from being exposed; uncertainty that surrounds future events and outcomes.

**Risk Communication:** Exchange of information concerning the existence, nature, form, severity or acceptability of health or environmental risks. Effective risk communication involves determining the types of information that interested and affected parties need and want, and presenting this information to them in a useful and meaningful way.

**Security:** Refers to the technological and managerial means by which States protect the availability, confidentiality, and integrity of an ESAR-VHP System and the information it contains.

**Server:** A computer or software application that provides services to other computers connected via a network.

**Situational Orientation:** A subset of training. It is training given to a health volunteer that corresponds to a specific emergency deployment. Situational orientation, also referred to as “just in time” training, is provided to health volunteers to prepare them for the specific situation in which they will provide assistance, and typically is recorded in the ESAR-VHP System database after the emergency deployment has been completed.

**Special Populations:** People who might be more sensitive or susceptible to exposure to hazardous substances because of factors such as age, occupation, sex, or behaviors (for example, cigarette smoking). Populations with special needs for translations, special services or alternative channels of communication (such as the deaf). Populations with distinct cultural or community needs. Children, pregnant women, and older people are often considered special populations.

**Sponsoring Entity:** The entity requesting the use of health volunteers. This group would assume liability for the health volunteer. This liability may be offset by separate agreement, State or protection.

**Spontaneous Volunteer:** Volunteer who arrives to provide services in response to an incident without being solicited for help or being specifically requested by a sponsoring agency involved in the emergency response.

**Staging Area:** Location established where resources can be placed while awaiting a tactical assignment.

**Stakeholder:** An individual, group, or organization that may be affected by or otherwise interested in a decision.

**State:** When capitalized, refers to any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States.

**Strategic:** Strategic elements of incident management are characterized by continuous long-term, high-level planning by organizations headed by elected or other senior officials. These elements involve the adoption of long-range goals and objectives, the setting of priorities; the establishment of budgets and other fiscal decisions, policy development, and the application of measures of performance or effectiveness.

**Strategic National Stockpile (SNS):** A national cache of drugs, vaccines, and supplies that can be deployed to areas struck by disasters, including bioterrorism.

**Strategy:** The general direction selected to accomplish incident objectives set by the IC.

**Surge Capacity:** The accommodation by the health system to a transient sudden rise in demand for health care following an incident with real or perceived adverse health effects. As neither the risk of surge nor the size of surge can be estimated, neither can surge capacity be estimated. The proper approach to surge is surge management planning rather than surge capacity planning.

**System Administrator:** Is a position responsible for operation and maintenance of the ESAR-VHP System.

**System Architecture:** Relating to the high level network approaches available to organize a system and achieve functionality; relating to the high level network approaches available for an ESAR-VHP System to achieve functionality.

**System Content:** A term relating to the primary and secondary information elements necessary for any organized system to meet its primary purpose and any secondary needs; relating to the primary and secondary information elements necessary to meet the primary purpose and secondary needs of the ESAR-VHP System.

**System Coordinator:** A position responsible for overseeing, directing, or assisting in the guidance of the overall activities of the ESAR-VHP System, including coordinating System use in a declared emergency.

**System Design:** A term relating to the three characteristics of ESAR-VHP System, specifically System Functions, System Content, and System Architecture.

**Terrorism:** The unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives.

**Testing Period:** The period during which the ESAR-VHP Guidelines, Standards, and Definitions will be formally reevaluated in cooperation with the ten States involved in phase I of the ESAR-VHP program. This period will extend from January 2005 to June 2005.

**Tools:** Those instruments and capabilities that allow for the professional performance of tasks, such as information systems, agreements, doctrine, capabilities, and legislative authorities.

**Training:** The formal activities and coursework taken by health volunteers to incrementally develop or enhance their ability to provide health services in a disaster scenario. Training must be specialized and acceptable to the State to prepare individuals to respond to a declared emergency. The training may be specific to different professional disciplines. Training, Disaster Training, and Disaster Preparedness Training are used interchangeably in the Guidelines.

**Unencumbered License:** An active and unrestricted State issued license.

**Verification:** The act of confirming truth or authority.

**Volunteer:** A medical or healthcare professional who renders aid or performs health services, voluntarily, without pay or remuneration. Also see **Health Volunteer**.

**Weapon of Mass Destruction (WMD):** A WMD is any device, material, or substance used with intent to cause death or serious injury to persons or significant damage to property.



## **Appendix 9: ESAR-VHP Guidelines Acronyms**

**ABMS:** American Board of Medical Specialties

**ACGME:** Accreditation Council for Graduate Medical Education

**AHA:** American Hospital Association

**AMA:** American Medical Association

**ANA:** American Nurses Association

**APN:** Advance Practice Nurse

**APRN:** Advanced Practice Registered Nurse

**ARC:** American Red Cross

**ASTHO:** Association of State and Territorial Health Officials

**BT:** Bioterrorism

**CDC:** Centers for Disease Control and Prevention. Division of DHHS

**CEU:** Continuing Education Unit

**CME:** Continuing Medical Education

**CMS:** Centers for Medicare and Medicaid Services. Division of DHHS

**CNM:** Certified Nurse Midwife

**CVO:** Credentials Verification Organization

**DDS:** Doctor of Dental Surgery

**DEA:** Drug Enforcement Administration

**DHHS:** Department of Health and Human Services (US)

**DHS:** Department of Homeland Security (US)

**DMAT:** Disaster Medical Assistance Team

**DMD:** Doctor of Dental Medicine

**DO:** Doctor of Osteopathy

**ECS:** Emergency Credentialing System

**EMAC:** Emergency Management Assistance Compact

**EMS:** Emergency Medical Services

**EOC:** Emergency Operations Centers

**ESAR-VHP:** Emergency System for Advance Registration of Volunteer Health Professionals

**FEMA:** Federal Emergency Management Agency (US). Division of DHS

**HAN:** Health Alert Network

**HEICS:** Hospital Emergency Incident Command System

**HIPAA:** Health Insurance Portability and Accountability Act

**HRSA:** Health Resources and Services Administration. Division of DHHS

**IC:** Incident Commander

**ICS:** Incident Command System

**JCAHO:** Joint Commission on Accreditation of Healthcare Organizations

**LPN:** Licensed Practical Nurse

**MD:** Medical Doctor

**MMRS:** Metropolitan Medical Response System

**MRC:** Medical Reserve Corps

**NBHPP:** National Bioterrorism Hospital Preparedness Program

**NDMS:** National Disaster Medical System

**NEDSS:** National Electronic Disease Surveillance System

**NEMA:** National Emergency Management Association

**NGO:** Nongovernmental Organization

**NIMS:** National Incident Management System

**NPDB:** National Practitioner Data Bank

**NPS:** National Pharmaceutical Stockpile

**OPHP:** Office Public Health Preparedness

**PA:** Physician Assistant

**PHERA:** Public Health Emergency Response Act

**PHIN:** Public Health Information Network

**RN:** Registered Nurse

**SNS:** Strategic National Stockpile

**SOC:** Standard Occupational Classification

**WEAVR:** Wisconsin Emergency Assistance Volunteer Registry

**WMD:** Weapon of Mass Destruction



## Appendix 10: List of US States and Territories

- Alabama
- Alaska
- American Samoa
- Arizona
- Arkansas
- Baker Island
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Federated States of Micronesia
- Florida
- Georgia
- Guam
- Hawaii
- Howland Island
- Idaho
- Illinois
- Indiana
- Iowa
- Jarvis Island
- Johnston Atoll
- Kansas
- Kentucky
- Kingman Reef
- Louisiana
- Maine
- Marshall Islands
- Maryland
- Massachusetts
- Michigan
- Midway Islands
- Minnesota
- Mississippi
- Missouri
- Montana
- Navassa Island
- Nebraska
- Nevada
- New Hampshire
- New jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Mariana Islands
- Ohio
- Oklahoma
- Oregon
- Palau
- Palmyra Atoll
- Pennsylvania
- Puerto Rico
- Rhode island
- South Carolina
- South Dakota
- Tennessee
- Texas
- U.S. Minor Outlying Islands
- Utah
- Vermont
- Virgin Islands
- Virginia
- Wake Island
- Washington
- West Virginia
- Wisconsin
- Wyoming

Source: <http://www.itl.nist.gov/fipspubs/fip5-2.htm>



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